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Performance Audit Division

Performance Audit

Department of Economic Security—Division of Children, Youth and Families—Child Protective Services—Timeliness and Thoroughness of Investigations

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

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AUDITOR GENERAL

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DEPUTY AUDITOR GENERAL

December 19, 2005

Members of the Arizona Legislature

The Honorable Janet Napolitano, Governor

Mr. David A. Berns, Director
Department of Economic Security

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Department of Economic Security, Division of Children, Youth and Families—Child Protective Services—Timeliness and Thoroughness of Investigations. This audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes §41-1966.

The report addresses the need for the Division to improve its investigations of child abuse and neglect reports. Investigations are a critical first step to ensuring children's safety and well-being. As such, it is important that investigations be timely as any delay may further jeopardize the safety of the child. Likewise, it is important that the investigation of the circumstances leading to the CPS report be thorough so that the services and supports needed to ensure safety and well-being can be provided.

The report found that even though the Division is statutorily required to investigate all reports in a prompt and thorough manner, some reports were not investigated, and many reports that were investigated did not meet statutory or division requirements for timeliness and thoroughness. The Division believes that unmanageable workloads, staff turnover, and the limited experience of some CPS supervisors and newly hired investigators are the primary contributing factors to its investigation problems and continues to take steps to address these issues. However, since these factors are likely to continue, additional meaningful changes are needed, including streamlining the investigation process and establishing effective oversight and accountability mechanisms.

As outlined in its response, the Department of Economic Security agrees with the finding and plans to implement or implement in a different manner all of the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on December 20, 2005.

Sincerely,

Debbie Davenport
Auditor General

Enclosure

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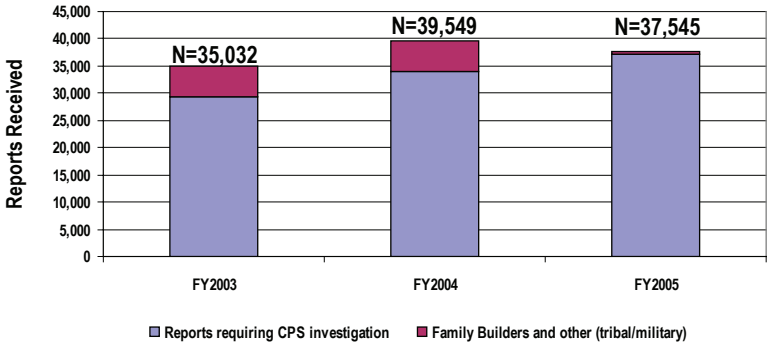
INTRODUCTION & BACKGROUND

The Office of the Auditor General has conducted a performance audit of Child Protective Services' (CPS) ability to respond to and investigate allegations of child abuse and neglect in a timely and thorough manner. CPS is a program within the Department of Economic Security's (Department) Division of Children, Youth and Families (Division). This audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes §41-1966.

The Division's CPS program is intended to protect children by investigating allegations of abuse and neglect while promoting the well-being of children in permanent homes and coordinating services to strengthen families. In fiscal year 2005, the Division received 37,545 reports alleging abuse or neglect involving 47,638 children.[1, 2] As shown in Figure 1, the number of reports received has increased by about 2,500 reports, or 7 percent, between fiscal years 2003 and 2005. During the same time period, the number of reports requiring investigation by CPS has increased by 27 percent, from 29,290 in fiscal year 2003 to 37,170 in fiscal year 2005.[3] Some of this increase is due to a legislative change that requires all reports previously referred to the Family Builders program to now be investigated by CPS.[4] The number of children

Figure 1: Child Abuse and Neglect Reports
Fiscal Years 2003 Through 2005



Source: Auditor General staff analysis of data on CPS reports received between July 1, 2002 and June 30, 2005, maintained in the Department's Children's Information Library and Data Source system.

1 Auditor General staff calculation based on automated CPS case data for fiscal year 2005 provided by the Arizona Department of Economic Security.

2 Children involved in one or more reports of abuse or neglect are counted only once.

3 The number of reports may vary slightly from those cited in division-prepared documents because of differences in the dates the information is extracted from the automated case management system. Because the system is real-time based, information is constantly being updated. The data auditors reported was extracted in July and August of 2005.

4 Prior to fiscal year 2005, CPS could refer certain low-risk and potential-risk child abuse reports to the Family Builders program. At that time, the program was an alternative response system comprising a network of community-based providers offering family-centered assessment, case management, and services. The reports referred to Family Builders, which totaled 5,464 in fiscal year 2003 and 5,128 in fiscal year 2004, were not investigated by CPS. However, as of July 2004, all reports, unless falling outside the agency's jurisdiction, must be investigated by CPS.

involved in CPS reports has grown 5.6 percent during the same time, which is in-line with Arizona's population growth of 5.2 percent.[1]

Investigations initiated by CPS reports

CPS Report Criteria

A communication meeting the criteria for investigation must include:

- An allegation that a person under the age of 18 is the subject of physical, sexual, or emotional abuse, neglect, abandonment, or exploitation;
- A parent, guardian, or custodian has:
  - inflicted,
  - may inflict,
  - permitted another person to inflict, or had reason to know another person may inflict,
  - or the alleged abusive person has not been identified and the parent, guardian, or custodian has not been ruled out as the person who inflicted, permitted another person to inflict or had reason to know another person would inflict abuse or neglect; and
- Contains sufficient information to locate the child.

Source: Department's *Child Abuse Hotline Procedures Manual*.

Reports of suspected child abuse are referred to CPS through a state-wide, toll-free, 24-hour child abuse hotline. Although anyone can report suspected abuse, more than half the communications are made by people who are mandated by law to report such instances, such as law enforcement personnel, school personnel, doctors, and other healthcare professionals. Centralized hotline workers respond to all telephone and written communications using a screening process to determine whether the situation warrants an investigation. During fiscal year 2005, the hotline received 111,539 communications, with 37,170 (33 percent) meeting the criteria for a CPS investigation.[2] In addition to determining which communications require a CPS investigation, hotline workers prioritize the reports, which determines how quickly an investigation must be started. As summarized in Table 1 (see page 3), the Division uses four categories to prioritize investigations, with the standard response time ranging from 2 hours for priority 1 reports, which are the most serious, to 7 days for priority 4 reports, which are considered potential abuse or neglect situations.[3] (See Appendix, pages a-iii to a-iv, for detailed information about the priority classification system).

A CPS report may include more than one allegation. Allegations are based on type of abuse and neglect, its severity, and the reported victim. For example, the report may include an allegation of priority 1 physical abuse for one child and priority 2 neglect for the same child and a sibling for a total of three allegations. As noted in Table 2 (see page 4), the percentage of allegations by type of abuse and neglect has remained stable across the past 3 years with neglect

1 Auditor General staff calculation of Arizona's population and CPS report growth rates was based on U.S. Census Bureau estimates for July 1, 2003, projections for July 1, 2005, and automated CPS case data for fiscal years 2003 through 2005 provided by the Arizona Department of Economic Security.

2 In addition to the communications requiring CPS investigation, the hotline received 357 communications requiring investigation that fell within the jurisdiction of military and tribal governments and were referred to those jurisdictions.

3 The standard priority timeline for starting an investigation can be aggravated or mitigated by a hotline worker or CPS supervisor based upon extenuating circumstances. For example, when a hospital worker makes a report to the hotline on a newborn testing positive for exposure to an illegal substance, the report will be assigned a priority 1. However, the response time of 2 hours may be mitigated by the hotline worker to 24 hours if the child is safe in the hospital and will not be released for at least another day.

Table 1: Summary of Child Abuse Report Priority Classification System

Priority 1 High Risk	**Priority 2 Moderate Risk**	**Priority 3 Low Risk**	**Priority 4 Potential Risk**
Response times: Standard within 2 hrs Mitigated within 24 hrs	**Response times:** Aggravated within 24 hrs Standard within 48 hrs Mitigated within 72 hrs	**Response times:** Aggravated within 48 hrs Standard within 72 hrs Mitigated within 72 hrs (excluding weekends and holidays)	**Response times:** Aggravated within 72 hrs (excluding weekends and holidays) Standard within 7 consecutive days
Physical abuse: Child death due to abuse, neglect, or suspicious death; severe or life threatening injuries requiring emergency medical treatment; and/or parent presents severe physical harm to the child now.	**Physical abuse:** Serious or multiple injuries which may require medical treatment, and/or a child is at risk for serious physical abuse if no intervention is received.	**Physical abuse:** Injuries not requiring medical treatment, and/or parent threatens physical harm to child if no intervention is received.	**Physical abuse:** Child at risk of physical injury due to stressors in the home.
Neglect: Severe or life-threatening situations requiring emergency intervention due to the absence of a parent, or a parent who is either unable due to physical or mental limitations or is unwilling to provide minimally adequate care.	**Neglect:** Serious or non-life-threatening situations requiring intervention due to the absence of a parent, or a parent who is either unable due to physical or mental limitations or is unwilling to provide minimally adequate care.	**Neglect**: Situations which may require intervention due to the absence of a parent, or a parent who is either unable due to physical or mental limitations or is unwilling to provide minimally adequate care, which includes exploitation of a child.	**Neglect**: Child at risk of neglect due to stressors in the home.
Sexual abuse: Physical evidence of sexual abuse reported by a medical doctor or child reporting sexual abuse within the past 7 days.	**Sexual abuse:** Sexual behavior or attempted sexual behavior occurring 8 days or up to one year ago, and/or child is exhibiting indicators consistent with sexual abuse.	**Sexual abuse:** Sexual behavior or attempted sexual behavior occurring beyond one year and perpetrator currently has access to a child.	**Sexual abuse:** NA
Emotional abuse: NA	**Emotional abuse:** Child diagnosed by a mental health professional as exhibiting symptoms of emotional abuse caused by a parent.	**Emotional abuse:** Parent demonstrates behavior which may result in emotional trauma to a child.	**Emotional abuse:** NA

Source: Department's *Child Abuse Hotline Procedures Manual.*

Table 2: Child Abuse and Neglect Allegations by Type and Priority
Fiscal Years 2003 Through 2005

	Fiscal Years					
	2003		2004		2005	
	Number of Allegations	Percentage of Total Allegations	Number of Allegations	Percentage of Total Allegations	Number of Allegations	Percentage of Total Allegations
Physical Abuse						
Priority 1	641	1%	786	1%	689	1%
Priority 2	3,496	5	3,999	5	3,811	5
Priority 3	7,119	11	8,139	11	8,736	11
Priority 4	4,862	8	5,425	7	6,228	8
Subtotal	16,118	25	18,349	24	19,464	25
Sexual Abuse						
Priority 1	292	<1	355	<1	383	<1
Priority 2	2,036	3	2,377	3	2,224	3
Priority 3	1,323	2	1,409	2	1,340	2
Priority 4	NA[1]	—	NA	—	NA	—
Subtotal	3,651	5	4,141	5	3,947	5
Emotional Abuse						
Priority 1	NA		NA		NA	
Priority 2	129	<1	182	<1	142	<1
Priority 3	1,253	2	1,601	2	1,422	2
Priority 4	NA	—	NA	—	NA	—
Subtotal	1,382	2	1,783	2	1,564	2
Neglect						
Priority 1	7,193	11	9,288	12	9,101	11
Priority 2	10,647	17	13,510	18	12,633	16
Priority 3	17,365	27	20,191	27	22,826	28
Priority 4	8,164	13	8,950	12	10,699	13
Subtotal	43,369	68	51,939	69	55,259	68
Death by Abuse						
Priority 1	22	<1	53	<1	42	<1
Death by Neglect						
Priority 1	22	<1	24	<1	35	<1
Total allegations in CPS reports requiring investigations	64,564	100%	76,289	100%	80,311	100%

[1] NA indicates the category has no priority classification.

Source: Auditor General staff analysis of CPS data maintained in the Department's Children's Information Library and Data Source system.

allegations comprising approximately two-thirds of total annual allegations. Similarly, the distribution of allegations by priority has also remained relatively stable over the years, with priority 1 allegations typically comprising the smallest percentage and priority 3 allegations typically comprising the largest percentage.

When it is determined that a CPS investigation is necessary, an investigative case manager will complete activities such as interviewing the alleged victim(s), perpetrator(s), and other knowledgeable sources to help assess the risk of harm to the child or children involved and evaluate the conditions that support or refute the alleged abuse or neglect. Statute requires that a finding be documented on each allegation within 21 days of the CPS report being made. Potential findings include "proposed substantiated," "unsubstantiated," or "unable to locate."

Based on the investigation, the Division may take one or more of the following actions:[1]

- **Close the case**—When the Division determines there are no risk factors severe enough to warrant ongoing involvement to ensure the children's safety, the Division may close the case after investigation without providing further services. Alternately, a case may be closed if the family refuses offered services and the risks to the child's safety are not severe enough to warrant legal action. The Department's automated CPS data indicates that 18,615, or 50 percent, of CPS reports received in fiscal year 2005 were closed after investigation without the family receiving services.[2]

- **Provide short-term services**—When the Division determines that a child is at risk for maltreatment, it may offer the family services such as counseling and parent skills training that could allow the child to live safely at home. These services, referred to as in-home services, may be provided directly by department staff, by contract, or through referral to community agencies. The services are typically provided for several weeks to several months, and the families participate in them voluntarily. The Department's automated CPS data indicates that the families who were associated with 14,416, or 39 percent of CPS reports received in fiscal year 2005, were provided with in-home services.

Criteria for Allegation Findings

- **Proposed substantiated** is used when there is probable cause, i.e., facts that provide reasonable grounds to believe the alleged abuse or neglect occurred.

- **Unsubstantiated** is used when there is not probable cause to believe the alleged abuse or neglect occurred.

- **Unable to locate** is used when the child victim cannot be located and there is insufficient evident to conclude that the child was abused or neglected without interviewing or observing the child.

Source: Department's *Children's Services Manual.*

1 The number of actions cited in the following bullets is based on the information recorded in the Division's automated case management system as of August 9 and 10, 2005.

2 Although families may not have received services paid for through the Department, they still may have been referred to community services. However, the Division does not currently have a mechanism for tracking this information.

- **File an in-home dependency or in-home intervention dependency**—When the Division determines that a child is currently safe but is at high risk of harm, and safeguards can be established to maintain the child's continued safety and well-being in his or her home, CPS may file an in-home dependency or an in-home intervention dependency with the local juvenile court. An in-home dependency petition, if approved by the court, makes the child a ward of the court and places the child in the physical custody of his/her parent(s). Under an in-home intervention dependency, the child is allowed to stay in his or her home when short-term intervention—up to 1 year—appears likely to resolve risk issues and the parent, guardian, or custodian agrees to a case plan and participation in services. The child does not become a ward of the court. However, if the parent, guardian, or custodian fails to comply with the case plan, the court may take whatever steps it deems necessary to obtain compliance or may award custody of the child to the State, at which time the child may be placed in out-of-home care. According to the Attorney General's Office, between January 1, 2004 and November 15, 2005, there were 360 in-home dependency petitions filed. In addition, there were 39 in-home intervention dependency petitions filed between January 1, 2004 and November 10, 2005.

- **File an out-of-home dependency**—When the Division determines that a child is in imminent danger of abuse or neglect, he or she may be removed from the home and temporarily placed in an approved foster care setting, such as with a relative or in a licensed foster or group home.[1] When this happens, the Division must either file a dependency petition with the local juvenile court within 72 hours or return the child to his or her family. If the court determines the child to be dependent, it will award custody to the State, and the child will remain in an out-of-home placement until the parent(s) address(es) the risk factors that prevent him and/or her from caring for the child safely at home. According to a department report, the number of children removed from their homes semiannually has increased by more than 50 percent between April 2001 and March 2005, with the greatest increases occurring between October 2002 and September 2003, as illustrated in Table 3.

Table 3: Number of Children Removed from Their Homes by the Department April 1, 2001 Through March 31, 2005

Reporting period	Number of children removed	Semiannual percent change
Apr 2001 – Sept 2001	2,387	NA
Oct 2001 – Mar 2002	2,501	5%
Apr 2002 – Sept 2002	2,655	6%
Oct 2002 – Mar 2003	2,961	12%
Apr 2003 – Sept 2003	3,349	13%
Oct 2003 – Mar 2004	3,504	5%
Apr 2004 – Sept 2004	3,630	4%
Oct 2004 – Mar 2005	3,617	0%

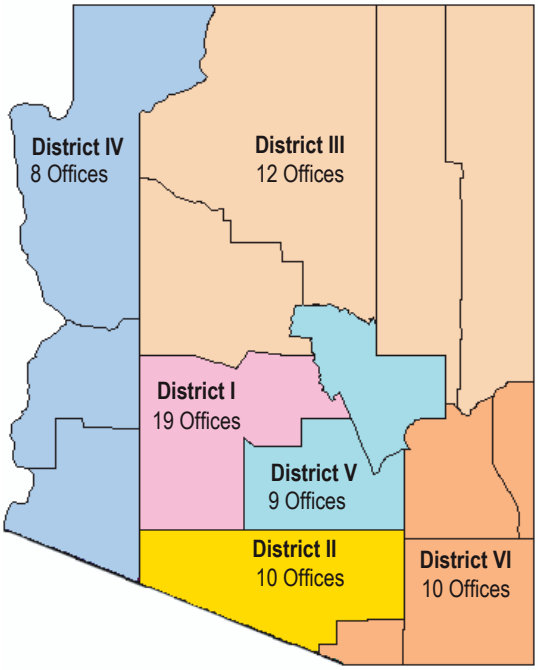
Source: Child Welfare Reporting Requirements Semi-annual Report prepared by the Arizona Department of Economic Security, Division of Children, Youth and Families, Administration for Children, Youth and Families.

[1] When CPS removes a child from his or her home, the Department is required to conduct a Removal Review Team conference within 72 hours of the child's removal. The purpose of this conference is to determine whether the removal was necessary, if there are alternatives to continued out-of-home placement, or if continued out-of-home placement is necessary and, therefore, an out-of-home dependency petition must be filed. Per A.R.S. §8-822, the Removal Review Team consists, at a minimum, of a CPS case manager and his or her supervisor, two members of the Foster Care Review Board, and the child's physician if the child has a medical need or chronic illness. If all reasonable efforts to reach the child's physician have been made and the physician is not available, the team shall include a licensed physician who is familiar with children's healthcare. Other qualified individuals such as a counselor or therapist may also be included in the review.

Organization, staffing, and budget

The CPS program provides child welfare services throughout the State. In order to accomplish this, CPS is organized into 68 offices within 6 regional districts (see Figure 2).[1] These offices are composed of one or more units typically consisting of a supervisor, 5 to 7 case managers, a case aide, and a secretary. In Districts I and II, the two urban districts, unit function is generally specialized. For example, case managers in one unit may handle only CPS investigations, while another unit may handle only ongoing services cases. In the 4 rural districts, the case managers in a single unit may be required to perform both investigations and ongoing case management. However, according to division management, each unit has at least one case manager dedicated to conducting CPS investigations.

Figure 2: Number of Offices by District
Fiscal Year 2005



Source: Auditor General staff analysis of the Division of Children, Youth and Families' Directory of Child Protective Services Offices.

The majority of the Division's employees work within the CPS program. The remaining employees provide administrative and support services to the Division. According to the Department, in fiscal year 2005, the Division had 1,793 full-time equivalent (FTE) positions, of which 871 were CPS specialists (i.e., case managers) and 152 were CPS supervisors.[2] In addition, there were another 4 FTEs classified as human service specialists who also manage CPS cases.

To provide CPS services, the Division receives both state and federal funding. Although the Division does not track expenditures by functional area, the Division estimates that it expended approximately $23 million on salaries and benefits for investigative and hotline staff in fiscal year 2005.[3] Part of the expenditure was for a stipend intended to help in the recruitment and retention of investigators that was

1 In addition to the 68 CPS offices, the Division has case management staff assigned to 7 non-DES locations, such as the Mesa Center Against Family Violence.

2 The numbers of CPS specialist and supervisor FTEs include 42 CPS specialists and 7 supervisors who work at the hotline, and exclude 47 CPS specialist FTE positions assigned for trainees. The Division's positions are funded by General Fund and Temporary Assistance for Needy Families (TANF) program appropriations and other nonappropriated federal program monies.

3 The Division estimated its investigative staff salary and benefit expenditures using the federally approved Arizona Random Moment Sample (RMS) time study methodology. This methodology measures the work effort of the entire group of eligible staff involved in the CPS program by sampling and analyzing the work efforts of a cross-section of the group. RMS methods employ a technique of polling employees at random moments over a given time period to determine the nature of the employee's work activities and tallying the results of the polling. The method provides a statistically valid means of determining what portion of the selected group of staff's workload is spent performing activities that are reimbursable by the federal government to allocate the labor costs of direct service staff to appropriate federal and state funding sources.

authorized during the 2003 Second Special Session.[1] The stipend equals 10 percent of a worker's base salary and is paid on a monthly basis to those investigators with at least 36 months of CPS experience who are assigned 6 or more CPS reports to investigate in the same month the reports are received. These reports are in addition to any existing cases already being worked by the investigator. The Division reports that it expended $538,000 on the investigative stipend in fiscal year 2005.

1 Legislation passed during the 2003 Second Special Session did not authorize any additional monies to the Department for the stipend.

FINDING 1

Investigations need to be improved to better ensure children's safety

To better ensure children's safety, the Division needs to improve its investigations of child abuse and neglect reports. Investigations are a critical first step to ensuring children's safety and well-being. However, even though the Division is statutorily required to investigate all reports, some reports were not investigated, and many reports that were investigated did not meet statutory or division requirements for timeliness and thoroughness. The Division believes that unmanageable workloads, staff turnover, and the limited experience of some CPS supervisors and newly hired investigators are the primary contributing factors to its investigation problems and continues to take steps to address these issues. However, since these factors are likely to continue, additional meaningful changes are needed, including streamlining the investigation process and establishing effective oversight and accountability mechanisms.

Investigations help ensure children are safe

Investigating child abuse and neglect reports is a critical first step for ensuring children's immediate safety and long-term well-being. As such, it is important that investigations be timely as any delay may further jeopardize the child's safety. Likewise, it is important that the investigation of the circumstances leading to the CPS report be thorough so that the services and supports needed to ensure safety and well-being can be provided. In addition to the immediate safety issue, there may be potential long-term consequences for children left in situations where they may be abused or neglected. According to a report from the National Clearinghouse on Child Abuse and Neglect Information, studies have found that abuse and neglect can have long-term physical, emotional, and behavioral consequences.[1] For example, shaking a baby (a form of physical abuse) may result in blindness, learning disabilities, mental retardation, or paralysis. Further, it is important that the information obtained during an investigation is documented in a timely manner in the automated case

1 National Clearinghouse on Child Abuse and Neglect Information. *Long-term Consequences of Child Abuse and Neglect.* Washington, D.C. (July 2005).

management system so that it is readily available to other CPS staff and management who may need it, such as after-hours staff responding to a subsequent report or supervisors monitoring workload and productivity.

Division failed to investigate some CPS reports

The Division has not investigated some of the CPS reports it has received. Further, auditors identified some additional reports for which it is unclear whether investigations were conducted or thoroughly completed. Despite this, the Division has been reporting to the Legislature that is has investigated 100 percent of the reports requiring investigation.

Some CPS reports have not been investigated—Despite a statutory requirement to investigate 100 percent of the CPS reports it receives and the importance of doing so to protect children, the Division has failed to investigate some of the reports it received between July 2002 and March 2005. Auditors' analysis of the automated case data for the 91,267 CPS reports received during this period found that 920 of these reports were missing both the date the investigator responded to the report as well as the investigation's results, known as allegation findings, which raised questions about whether these reports had been investigated. Statute requires that allegation findings be entered in the Division's automated case management system within 21 days of receiving the report. Further, division policy requires that all documentation on the investigation, including the initial investigation response date, be completed within 45 days of the investigator's receiving the report.

Auditors examined the complete case records for a judgmental sample of 15 of the 920 reports and found that 3 had not been investigated by CPS.[1] Specifically:

- CPS received a report in November 2003 alleging priority 2 sexual abuse of the alleged perpetrator's 10-year-old daughter, but there was no evidence of an investigation occurring.

- CPS received a report in June 2004 alleging priority 2 physical abuse of a child under the age of 2, but there was no evidence of an investigation occurring.

- CPS received a report in October 2004 alleging priority 3 physical abuse of a 7-year-old child, but there was no evidence of an investigation occurring.

Division management has since directed CPS staff to review the remaining reports to determine whether any additional reports were not investigated. Although the Division reports that it has completed this review, auditors found problems and inconsistencies with the review's conclusions and therefore it cannot be reliably

[1] A case record comprises an electronic and hard copy record. The electronic record is maintained in the Division's automated case management system and includes information on the Division's investigative activities, findings, and decisions. The hard copy record includes documents generated outside the Division, documents that require signatures from individuals outside the Division, and hard copy forms not maintained electronically.

determined how many of these 920 reports were or were not investigated. While the Division found evidence that some of these reports were investigated, in other instances the investigations had only occurred within the past few months even though the reports had been received months or even years earlier. Further, in other instances, even though the Division indicates that the reports were investigated by CPS, the case records do not support this assertion. For example:

- In July 2004, a law enforcement officer reported to the hotline allegations of priority 4 neglect involving 2 children. In November 2004, 3-1/2 months after the report was received, it was assigned to a CPS investigator. However, the automated case management system does not contain any information regarding an investigation by CPS. In fact, the only other information in the system shows that in September 2005, 14 months after the report was received, finding allegations were entered in the system but they appear to be placeholders because there is a comment related to the allegation findings that says "investigation continuing—determination is still being made as to findings."

Unclear whether other investigations were conducted or thoroughly completed—For some additional CPS reports, it is unclear whether investigations were conducted or thoroughly completed because important information is missing from the automated case management system. For example, auditors' analysis of the automated case data for the 91,267 CPS reports received between July 2002 and March 2005 found another 651 reports that had an initial investigation response date recorded in the automated case management system, but were still missing any allegation findings as of July 21, 2005. The recording of allegation findings signifies that the investigation has been completed and it documents the investigator's conclusions. In addition, there were another 76 reports that had allegation findings recorded in the system for some, but not all, of the allegations. In both examples, many of the reports were received in fiscal years 2003 and 2004. Auditors also noted entries in the electronic case records of a few reports where division staff questioned or could not determine whether there had been an investigation because there was no information in either the hard copy records or the automated system regarding what occurred during the investigation.

Division inaccurately reports 100 percent investigation rate—Although auditors found instances where CPS reports were not investigated and lack of documentation in the system to support whether other investigations were conducted or thoroughly completed, the Division has routinely reported in its Child Welfare Reporting Requirements Semi-annual Report that it has investigated 100 percent of the reports requiring a CPS investigation. The semiannual reports further note that the Division has maintained this investigation rate since 1998. However, this rate is based on whether a report is *assigned* for investigation, not on whether it has *actually* been investigated. A more appropriate measure of investigation rate would be based on the number of CPS reports received that have findings for all allegations and for which the supervisor has reviewed and approved the findings. This would

require a modification to the automated case management system to capture supervisor approval of each of the allegation findings.

Division has not conducted some investigations and other actions in a timely manner

Although the Division is statutorily required to conduct prompt investigations, staff have not consistently met statutory and policy time frames for initiating investigations, conducting the investigative work, documenting investigative results or allegation findings, and closing or transferring investigations for ongoing case management. It is important that these actions occur in a timely manner to ensure the safety of children, as well as to initiate additional reviews, ensure information is available if a subsequent report is received on the same family, and for management to monitor staff workload and productivity.

Division has not initiated some investigations in a timely manner and does not know when other investigations began—Although the Department is statutorily required to conduct prompt investigations of child abuse and neglect to ensure the children's safety and well-being, it has not initiated some investigations in a timely manner and does not know when it began some other investigations. Division policy outlines the time frames within which an investigator must begin investigating a CPS report. For example, if the report has been classified as priority 1, the investigator has 2 hours from the time the report is transmitted from the hotline to the local office to initiate action to determine the safety of the children involved. Auditors' analysis of the automated case data for the 91,267 CPS reports received between July 2002 and March 2005 found that only 49,197, or 54 percent, had investigations initiated within the outlined time frames; 11,363, or 12 percent, were not initiated within the outlined time frames; and 30,707, or 34 percent, had missing or invalid investigation response dates, making it impossible to tell if the investigations were initiated in a timely manner. As illustrated in Table 4 (see page 13), of the investigations that were not initiated on time, most were initiated in 5 or fewer days, but 1,253 investigations, or 11 percent, were started more than 30 days late.

Most of the reports with missing and invalid response dates—approximately 25,000—were due to invalid response dates. Invalid response dates arise when the response date precedes the date the report was assigned for investigation. According to division staff, invalid dates may be a result of typographical errors; recording the date emergency personnel, such as the police, responded to the situation (rather than the CPS investigator); or the Division's practice of not recording in the automated case management system the assignment of a report for investigation when the family surname is unknown until the investigator has identified the family. In order for the Division to effectively monitor investigative timeliness, it will need to address these issues through adding edits to the automated system to prevent invalid dates being input, clarifying policy to clearly indicate that the CPS

Table 4: Compliance with Initiating Investigations Within Policy Time Frames Reports Received from July 1, 2002 Through March 31, 2005

	Total	Priority 1 High Risk	Priority 2 Moderate Risk	Priority 3 Low Risk	Priority 4 Potential Risk
Number of investigations initiated within policy time frames	49,197	5,382	14,571	20,952	8,292
Number of investigations with missing or invalid response dates	30,707	10,265	9,138	8,796	2,508
Number of investigations not initiated within policy time frames[1]					
Delayed 1 day or less	3,185	547	964	1,422	252
Delayed 2 to 5 days	4,185	236	1,389	2,274	286
Delayed 6 to 10 days	1,303	57	387	672	187
Delayed 11 to 20 days	1,018	24	308	554	132
Delayed 21 to 30 days	419	8	136	214	61
Delayed over 30 days	1,253	46	356	657	194
Total	11,363	918	3,540	5,793	1,112

[1] The timeliness analysis of initiating report investigations takes into account aggravated and mitigated time frames.

Source: Auditor General staff analysis of data on CPS reports received between July 1, 2002 and March 31, 2005, maintained on the Department's Children's Information Library and Data Source system.

investigator's response time must be recorded in the automated case management system even if emergency personnel are also involved, and modifying the automated case management system to allow the recording of a report assignment with an unknown family surname and then later merge it with any prior cases once the family surname becomes known.

Division has not always conducted investigation work promptly—Not only is it important that investigations be initiated in a timely manner, it is also important that all of the needed investigative work be conducted promptly to ensure children's safety and ensure that needed services are provided in a timely manner. Statute requires that an investigation be completed within 21 days of a report's receipt. However, auditors noted that the investigations for some of the 920 reports discussed earlier languished for months or even years after the report was received. For example:

- In January 2003, CPS received a report alleging priority 3 physical abuse of a 5-year-old child by his father. The report was assigned to an investigator who initiated an investigation in February 2003 by attempting to contact the child at school and the family at their home twice during a 10-day period. During both attempted home visits, the investigator reported knocking on the door several

times and leaving her business card. However, no additional investigative work was performed until September 2005, more than 2-and-1/2 years after the report was received, when the same investigator contacted several schools and found out where the child was now attending school. The investigator obtained the family's address from the school and conducted a home visit. During the home visit interview, the parents denied the allegations. A week later, the investigator interviewed the alleged child victim and his brother at school. Both of them denied the incident. The investigator subsequently unsubstantiated the allegation, citing "No evidence of physical abuse or neglect was found to request proposed to substantiate."

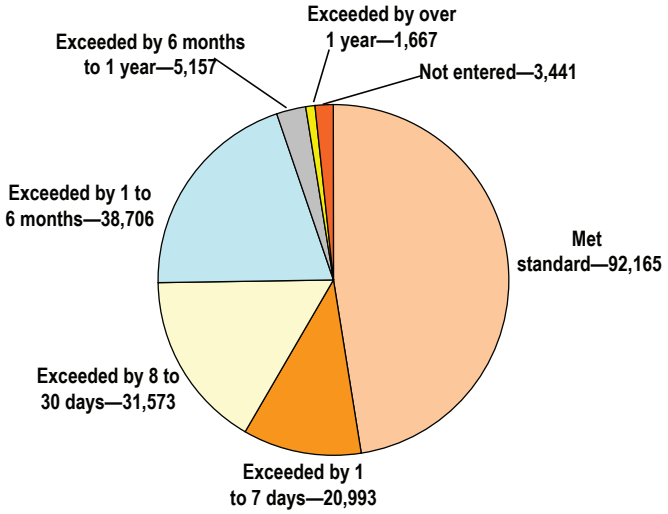
- On January 14 and January 19, 2005, two separate reports were received on the same family alleging priority 3 physical abuse and priority 2 sexual abuse of the alleged perpetrators' 11-year-old adopted daughter. However, no investigative activities were performed until July 2005, 6 months later, when a CPS unit supervisor discovered that these reports had never been investigated. The assigned investigator telephoned the adoptive father and set up an appointment for a home visit. However, on the date of the scheduled visit, no one was home. The visit was rescheduled for 2 weeks later, at which time the investigator went to the home and interviewed the father and child. The investigator unsubstantiated the allegations the next day, citing "Child was seen and interviewed on 8/2/05. Child did not disclose abuse or neglect. There is no evidence to support a substantiated finding. Child appeared healthy and developmentally on target."

Division has not always recorded investigation results in a timely manner—Although investigators are statutorily required to record the investigation results or allegation findings in the automated case management system within 21 days of receiving a report, investigators have frequently failed to do so. Recording the allegation findings is important because it indicates that the investigation has been completed.

It is also important that the allegation findings be entered into the system in a timely manner for a number of other reasons. First, if an allegation is proposed for substantiation, it is referred to the Protective Services Review Team within CPS, which reviews the investigation to ensure it was thorough and the evidence supports the proposed substantiation. Second, if it is determined that an allegation was unsubstantiated, CPS must inform the child's parent(s) or guardian(s) of the investigation's outcome if he/she either made the report or was the alleged perpetrator. Third, if a subsequent CPS report is made on the family or the alleged perpetrator, the investigator will be able to factor the allegation findings into the subsequent report. Finally, recording allegation findings allows CPS management to monitor investigator workload and productivity.

However, auditors' analysis found less than one-half of the allegation findings were entered into the system on time. Auditors analyzed the automated case data for the 193,702 allegations included in CPS reports received between July 2002 and March 2005 and found that as of July 21, 2005, a total of 92,165, or 48 percent, of the allegation findings were entered into the automated case management system on time (see Figure 3). Of the 101,537 allegation findings that were not entered into the system on time, 45,530, or 45 percent, of the allegation findings were entered a month or more after the required time frame, and 3,441, or 3 percent, of the allegations were still missing findings. Therefore, it was not readily apparent whether those investigations have been completed.

Figure 3: Compliance with Entering Allegation Findings Within 21 Days of Report Receipt Reports Received from July 1, 2002 Through March 31, 2005

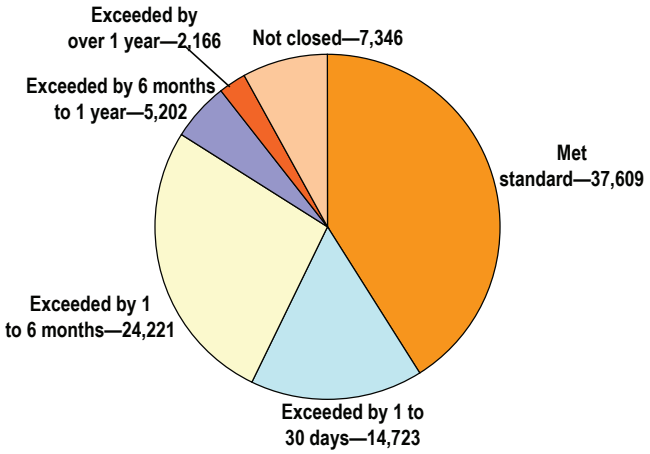


Source: Auditor General staff analysis of data on CPS reports received between July 1, 2002 and March 31, 2005, maintained on the Department's Children's Information Library and Data Source system.

Division has not always closed or transferred investigations in a timely manner

—Although division policy requires that within 45 days of a report's receipt the investigator is to either close the case in the system or transfer it for ongoing case management, investigators have frequently failed to do so. It is important that investigations be closed or transferred in a timely manner because these actions ensure that the investigation undergoes supervisory review to make sure it is thorough and complete and that children and families are promptly receiving any needed services. Further, failure to close or transfer investigations in a timely manner results in an inaccurate picture of the number of active investigations and hinders management's ability to monitor and manage investigator workload and productivity. However, auditors' analysis found that less than one-half of the investigations initiated from reports received between July 2002 and March 2005 were closed or transferred on time. As noted in Figure 4, as of July 21, 2005, 37,609, or 41 percent, of the investigations were closed or transferred on time while 7,368, or 8 percent, were closed or transferred 6 months or more after the required time frame; and 7,346, or 8 percent, of the investigations still had not been closed or transferred.

Figure 4: Compliance with Closing or Transferring Investigations Within 45 Days of Report Receipt Reports Received from July 1, 2002 Through March 31, 2005



Source: Auditor General staff analysis of data on CPS reports received between July 1, 2002 and March 31, 2005, maintained on the Department's Children's Information Library and Data Source system.

Some investigations not thorough

Although the Division is statutorily required to conduct thorough investigations to ensure child safety and it has developed policies to help ensure staff meet this requirement, the Division has not ensured adherence to the policies. Auditors randomly selected and reviewed the hard copy and electronic records for 30 of the 18,839 CPS reports received between October 1, 2004 and March 31, 2005, and found four key areas where staff have not consistently followed policies to ensure thorough investigations. Specifically:

- **Independent supervisory review of prior reports not always occurring**—Although required by policy, investigators have not always obtained an independent supervisory review of new CPS reports when three or more prior reports existed. The intent of this review by supervisory personnel unconnected to the case is to determine, among other things, whether all allegations in previous reports were addressed; whether a pattern of cumulative harm to the identified child victim or any other child residing in the home is evident or emerging; and whether additional information, such as school records or mental health records, should be obtained. Eleven of the 30 reports auditors reviewed met the criteria for an independent review because each had between 3 and 12 prior reports. However, there was no evidence that an independent review had occurred for any of these reports. One of the reports that should have undergone an independent review had 5 prior substantiated reports comprising 25 allegations of neglect and abuse ranging from priority 1 to priority 4.

- **Reasonable efforts to locate and contact the child victim and his/her family not consistently occurring**—Although division policy requires investigators to make reasonable efforts to locate and contact the alleged child victim and his or her family to ensure the child is safe and assess whether services are needed to ensure the child's continued safety, auditors' review noted 10 instances where investigative efforts did not appear adequate. The case example in the textbox (see page 17) illustrates a situation in which insufficient action was taken to contact the child victims, and as a result, needed services were unnecessarily delayed.

- **Child safety assessments not consistently completed or approved as required**—Investigative staff have not always completed a child safety assessment at the conclusion of an investigation, and even when they were completed, supervisors had not always reviewed and approved these documents. Division policy requires that a child safety assessment (CSA) be conducted as part of every investigation to assess the present and/or foreseeable danger of serious harm to children in the family and, if appropriate,

Case Example

In March 2005, a CPS report was received citing priority 2 allegations of neglect involving two children, ages 10 and 17. Although the family had received two prior reports alleging similar allegations in October and December of 2004, there was no evidence that the case manager who was assigned to the two prior reports ever contacted the children or did other important investigative tasks. A month after the second report was received, another case manager was asked to assist the assigned case manager with the investigation; however, the Division did not ensure that the family and the victims were contacted. Specifically, the assisting case manager attempted but was unable to visit the family at its home. Although the assisting case manager was informed by the mother that he should visit the children at school, he was unavailable to assist with the investigation during school hours. Further, although the assisting case manager informed the supervisor of this situation, she did not assign someone else to interview the children. Therefore, it was not until the third report was received in March 2005 and a different case manager was assigned that a thorough investigation took place. As a result, the youngest child was removed from his home so that he could receive medical and clinical treatment for several serious mental health disorders. Additionally, the following services were provided to the family: out-of-home placement for the youngest child, psychological evaluations for the youngest child and mother, and parent aide services and substance abuse treatment for the mother.

to develop a safety plan.[1] Investigators are required to complete a CSA within 24 hours after first seeing the alleged child victim and at the conclusion of the investigation; however, auditors found that for 13 of the 30 investigations, there was no evidence that a CSA was completed at the conclusion of the investigation, nor any indication why the assessment had not been completed. Policy also requires supervisors to sign and date the completed hard copy CSA to indicate their review and approval of the overall assessment and safety plan. However, auditors found that for 9 of the 30 investigations, supervisors had not signed and dated the CSA.

- **Information recorded on system does not consistently reflect investigation findings**—Despite division policy that outlines the criteria for allegation findings, auditors' review of 30 hard copy investigative files and associated electronic case records noted instances where the allegation findings entered into the automated case management system did not accurately reflect the outcome of the investigation. For example, in the case example cited above, even though the three reports appear to validate the allegations of neglect of the younger child and were proposed for substantiation by the investigator in consultation with her acting supervisor, they were subsequently modified to unsubstantiated by another supervisor with no explanation. In another example, the investigator unsubstantiated priority 2 neglect allegations involving two children even though she never made contact with the children. The supervisor assigned to the investigation later told auditors that the findings should have been recorded as "unable to locate."

1 When conducting a CSA, investigators determine the potential for present or foreseeable danger of serious harm to a child through assessment of 17 safety factors, such as whether sexual abuse is suspected and whether circumstances suggest that continued sexual abuse is an immediate concern, or whether drug and/or alcohol use by the caregiver or others living in or having access to the home places the child in immediate danger.

Investigation documentation not always current, accurate, or complete

Although division policy requires that the case records be current, accurate, and complete, auditors identified problems in each of these areas. First and foremost, the case record information is crucial in assessing and ensuring child safety. It is also important for other critical functions, such as for after-hours and other staff addressing urgent situations when the assigned investigator is not available and for the safety assessment and decision-making process if a subsequent report on a family is received. Because the appropriateness of decisions made using case data is contingent on the data's quality, inaccurate or incomplete information may lead to poor or dangerous decisions. In addition, current, accurate, and complete case records are needed for management to adequately monitor staff workload and productivity.

Despite the importance of documentation, previous audits as well as this one have identified problems with the case record documentation. For example, a May 2005 performance audit of the Division's data integrity process found that there were errors and omissions in the automated system's data, and 48 percent of the case management staff responding to an auditor survey reported that data problems hindered their ability to efficiently and effectively perform their job duties. Further, 13 percent of the case management staff responding to the survey reported that data problems hindered their ability to ensure child safety and well-being (see Auditor General Report No. CPS-0501). The Division agreed with this finding and plans to implement all recommendations. Additionally, although policy requires the electronic case record to be updated no more than 10 days from the date of the event being documented, this audit found examples where investigative information was not recorded until months or even years after the investigation was conducted, sometimes with questionable accuracy. For example:

- In August 2005, 2-and-1/2 years after an initial CPS report was made, a former CPS supervisor entered information into the system indicating that an investigation was conducted 2 months after the report was received and that the alleged physical abuse of the 6-month-old by his father was unsubstantiated because no bruising was evident. Further, the mother indicated the father had returned to Texas and she was going to raise the child on her own away from the father's violent behavior. According to the supervisor, during this audit she obtained this information by telephone from the CPS investigator whom this report had been assigned to (this individual had not worked for the Department for over 2 years). However, the accuracy of this information is questionable because the date of the case manager's visit to the child is recorded in the system as taking place 2 months after the case manager resigned from the Department. Auditors subsequently spoke with the former CPS investigator, and the information he provided leads auditors to further question the accuracy of the information in the system. Specifically, the former CPS investigator provided auditors with information that conflicts with the information the supervisor

recorded in the case management system. For example, he reported to auditors that he interviewed the father, but the information in the system noted that the father had moved to another state and only the mother was interviewed.

Further, in some instances the case record documentation is not complete. For example, although policy requires at the close of an investigation that the investigator document a case note narrative in the Division's automated case management system that summarizes the progress, events, concerns, and crucial information related to the investigation, auditors found many examples where this did not occur. One example involved allegations of neglect and physical abuse of two children where the family had an ongoing history of alleged abuse and neglect. The closing summary indicated only that "the case was staffed with a supervisor to discuss the allegations, it was determined the allegations would be unsubstantiated, and the case would be approved for closure." There was no mention of the prior case history, the basis for the unsubstantiated findings, or whether services had been offered to and accepted by the family. If prepared properly, closing summaries can be used by subsequent workers to quickly obtain a comprehensive picture of what occurred during prior investigations without having to read the entire case record. Therefore, the Division needs to ensure that investigators include in their investigative documentation a comprehensive closing summary. One way to improve documentation may be for the Division to adopt, for state-wide use, the closing summary template used in districts 3 and 4. The template guides investigators and ongoing case managers to document information such as the original reason for service, present whereabouts of the children, progress made in services/achievement of goals and objectives, justification for case closure, areas where problems may recur, description of aftercare plan and services, case manager's assessments of the family, and date and description of the last face-to-face contact.

Additional actions needed to improve investigative performance

The Division needs to take additional steps to improve its investigative performance. The Division attributes its investigation problems primarily to unmanageable workloads, staff turnover, and the limited experience of some CPS supervisors and newly hired investigators and continues to address these issues. However, since these factors are likely to continue, additional meaningful changes are needed, including streamlining the investigation process and establishing effective oversight and accountability mechanisms.

Division taking steps to address ongoing barriers hindering investigative performance—Division personnel attribute many of the investigation problems to unmanageable workloads, staff turnover, and the limited experience of some CPS supervisors and newly hired investigators. Between 2002 and 2006, in an effort to ensure manageable workloads, the Division has increased

the number of its CPS case management and support staff positions by 551.[1] However, according to division management, this has not resolved the workload issue because of continuing problems with hiring and retaining staff. The Division reports that as of June 2005, it had 165 case manager positions vacant and an annualized turnover rate of 19.8 percent.[2] Although it also had 163 staff in training to fill the vacant positions, the program administrator indicated that due to the complexity of the job, it takes staff a year or more to become experienced and competent in their jobs, which impacts their ability to manage their workloads. The quality of supervisory oversight is also being impacted because when vacancies occur, supervisors are assisting with investigations which, in turn, limits their ability to supervise the staff in their units. Similar issues were cited in a 1997 performance audit of the Division's investigative performance (Auditor General Report No. 97-18).

The Division indicates that it has already implemented or is in the process of implementing additional steps to address unmanageable workloads and the limited experience of some of its supervisors. Specifically:

- Division implementing strategies for recruiting and retaining staff—The Division has initiated actions to improve staff recruitment and retention. For example, the Division is participating in a multi-state, 5-year study to identify effective strategies for recruiting and retaining quality and experienced case management staff. As a part of this study, the Division has developed recruitment and retention strategic plans for two pilot sites, one in Phoenix and the other in Casa Grande. Some of the plans' goals include developing local recruiting plans, modifying the interview process, and providing prospective candidates a better understanding of case management work using realistic job videos. If these strategies prove successful, the Division plans to integrate the project into its division-wide strategic plan.

  The Division also continues to use stipends in an effort to recruit and retain case management staff. For example, the Division has a $1,300-per-year "rural recruitment and retention" stipend that is available to all CPS specialist IIs and IIIs, supervisors, and program specialists in the four rural districts as these individuals are responsible for ensuring the safety and welfare of children in their communities 24 hours a day, 7 days a week. Similarly classified employees in districts 1 and 2 do not receive the stipend because these districts have permanent after-hour investigative teams available to provide 24-hour coverage. In addition, in 2003 the Department received approval for an investigative stipend. This stipend equals 10 percent of base pay and is available to investigative workers with at least 36 months of CPS experience who take on 6 or more CPS reports during the month the reports are received. During fiscal year 2005, the Division paid an average stipend of $2,306 to its case managers

1 The additional positions are funded by General Fund and TANF appropriations and other nonappropriated federal program monies.

2 Auditors noted some discrepancies in the Division's reported filled positions, which the Division is working with auditors to reconcile.

and supervisors, with the actual stipends ranging from $295 to $4,819. Finally, according to division management, the Department has discussed with its personnel office the possibility of offering a geographic stipend to attract and retain staff in some of the "hard-to-staff" rural areas including Yuma, Bullhead City, Kingman, Prescott Valley, Winslow, and Lake Havasu.

- **Division implementing supports to help workers manage their workloads**—The Division has also taken action to help investigators manage their workloads. For example, in April 2004, the Division began implementing a "support response team" protocol that requires each district to make available one staff person to assist with investigating CPS reports. If a district falls behind in responding to investigations, the district e-mails the central office administrator, who will approve the support team to assist the struggling district for up to 2 weeks. According to division management, the team has been used three times. Additionally, because of the vacancies in all the districts, the administrator has been using central office staff with previous experience in CPS investigations, supervision, and/or case management to provide assistance to the districts.

  The Division is also establishing in-home service units, which it believes should help reduce the workloads of some investigators. Typically, when an investigative case is completed and findings have been recorded for all the allegations, the case will be closed or transferred to an ongoing worker who will arrange for and monitor the family's participation in services.[1] These ongoing workers have traditionally managed both in-home and out-of-home cases. While in-home services cases primarily involve monitoring a family's voluntary participation in services, out-of-home cases involve many additional actions including filing a dependency petition, developing and monitoring a case plan, and routinely meeting with the child and his or her family and foster caregiver. According to division personnel, some investigators will retain an in-home services case in their workload and monitor the family's participation in services rather than transfer it to an ongoing case manager they believe already has a heavy workload. However, once the in-home services units are established, the completed investigation cases requiring in-home services will be transferred to these new units. The Division plans to staff the units with the 137 new case management positions authorized in fiscal year 2006 and plans to have these units in place in all districts by January 2006.

- **Division implementing an online reporting tool to enhance reporting and monitoring**—According to the Division, it is implementing a new online automated case management system reporting tool that will allow management, supervisors, and CPS staff to view collected data, analyze trends, and monitor performance. The Division plans to use the reporting tool initially to report and monitor response times for CPS investigations, timeliness of CPS investigations, and timeliness of case manager visitations with children and

[1] The cases retained by investigators are those where the family is receiving services, but no children have been removed from the home.

families. According to division management, the reporting tool will be implemented in January 2006.

Although the Division plans to implement the tool to enhance its reporting of automated case management data and monitoring of related CPS activities, division management should not underestimate the impact that unreliable data may have on the Division's ability to effectively implement the tool. In order for the Division to fully utilize the tool and maximize its effectiveness, the data maintained in the automated case management system must be timely, complete, and accurate.

Additional steps needed to improve investigative performance—This audit found that although the Division has policies and oversight processes that are designed to help ensure that staff conduct timely and thorough investigations, these mechanisms are not working as intended. Therefore, the Division needs to focus on making meaningful changes to these mechanisms. Specifically:

- Streamline investigative tasks—The Division needs to significantly streamline the investigative process. This recommendation is particularly important because it is likely that the Division will always struggle with recruitment and retention issues. This recommendation was most recently made in a May 2005 performance audit of CPS' data integrity process (see Auditor General Report No. CPS-0501). In that report, it was noted that the Division had established a workgroup in 2002 to develop recommendations for reducing investigative tasks while still ensuring children's safety. However, this workgroup was only of limited duration, and while it developed recommendations, they were not all implemented. For example, the workgroup recommended that when law enforcement involvement is necessary, the hotline worker rather then the CPS unit should e-mail the police version of the CPS report directly to law enforcement after sending the report to the responsible CPS investigative unit. Further, the workgroup did not perform a comprehensive review of all the processes impacting the investigations area and focused only on those processes implemented state-wide, even though each district may develop additional processes that take into account factors unique to them. Therefore, the audit report recommended that the Division conduct a comprehensive and systematic review of its processes to identify those that can be streamlined or eliminated.

- Increase accountability—Division administration needs to determine its top priorities for the investigative function and hold staff accountable for achieving them. Specifically, the Division needs to identify the top three to five areas that are most important to the investigative process and then focus on those areas. Examples of potential priorities could include 1) investigating all CPS reports, 2) conducting investigations according to statutory and policy requirements, 3) documenting investigative activities completely and accurately, and 4) providing required supervisory oversight.

Division administration also needs to better use management reports to monitor performance in these critical areas. While the Division has monthly exception reports on issues such as reports missing allegation findings, as found in the May 2005 CPS performance audit and this audit, the reports are not being effectively used to resolve the exceptions. Also, although the six districts have developed monitoring mechanisms, they are varied in terms of what and how information is being tracked, and therefore, are of limited value to department and division administration for tracking overall performance and targeting problem areas. Therefore, the Division should revise or develop additional management reports that will better allow administration to routinely assess performance in critical areas, both overall and at targeted levels such as offices or units. However, for these reports to be of value, the Division will need to ensure the underlying data is accurate and complete.

Finally, division administration needs to establish accountability at all staff levels for making sure the priorities are achieved. While the Division has a process for evaluating staff performance against expected standards using annual written evaluations, it appears that the evaluations are not always being conducted. This may be partly because there is no central mechanism for tracking when performance evaluations are due or performed. Department personnel recognize the lack of a centralized mechanism as a barrier to ensuring that staff evaluations are performed in a timely manner. However, it is left up to a worker's immediate supervisor to monitor this information. Auditors reviewed ten personnel files and found that five were missing one or more required evaluations. To ensure employees are held accountable for achieving the Division's priorities and expectations, the Division's personnel unit should implement a centralized tracking system to make certain staff receive their required annual evaluation. Further, this tracking system should also record each staff person's overall performance rating for the year so that management can readily identify those workers in need of corrective action.

- Communicate importance of documentation—Division management should communicate to its employees the importance of recording timely, accurate, and complete documentation in the automated case management system to help ensure child safety and well-being. Management philosophy has a significant influence on the Division's operations and because of workload concerns, management has notified case management staff that documenting information is a secondary priority to ensuring child safety. However, the Division should not overlook the negative impact that incomplete and untimely documentation can have on a child's continued safety and well-being, as well as the investigator's ability to investigate CPS reports and substantiate allegations of abuse and neglect where appropriate.

Recommendations:

1. To ensure the Division's reported investigation rate accurately reflects investigated reports, the Division should base the rate on the number of CPS reports received that have findings for all allegations and for which the supervisor has reviewed and approved the findings. This will require a modification to the automated case management system to capture supervisor approval of each of the allegation findings.

2. To ensure the Division can effectively monitor investigation timeliness, it needs to take the following actions to better ensure accurate data on initial response time:

    a. Add edits to the automated case management system to prevent invalid dates being input.

    b. Clarify policy to clearly indicate that it is the CPS investigator's response time that must be recorded in the automated case management system, even if emergency personnel are also involved.

    c. Modify the automated case management system to allow the recording of the assignment of a report with an unknown family surname and then later merge it with any prior cases once the family surname becomes known.

3. To better ensure the safety and well-being of child victims of abuse and neglect, the Division should investigate 100 percent of reports requiring CPS investigation.

4. To improve the usefulness of the investigation closing summary documentation, the Division should ensure that investigators document consistent and comprehensive information.

5. To better ensure investigative performance is timely and thorough, the Division should:

    a. Establish three to five priorities that are most important to the investigative function and would demonstrate that the Division is performing efficiently and focus on these areas.

    b. Develop and use additional management reports or other mechanisms to keep division administration apprised of investigative performance in the established priority areas so that timely corrective action can be taken if needed.

c. Hold staff accountable for achieving the Division's priorities and expectations by requiring the Division's personnel unit to implement a centralized tracking system to record when staff evaluations are due and conducted and each person's overall performance rating so that management can readily identify those workers in need of corrective action.

6. Because of the negative impact that untimely, inaccurate, and incomplete documentation can have on a child's continued safety and well-being, as well as an investigator's ability to investigate CPS reports and substantiate allegations of abuse and neglect where appropriate, division management should communicate to staff the importance of recording timely, accurate, and complete documentation in the automated case management system.

APPENDIX

Appendix: Child Abuse Hotline Report Priority Classification System

Priority 1 High Risk	Priority 2 Moderate Risk	Priority 3 Low Risk	Priority 4 Potential Risk
Response times: • Standard within 2 hrs • Mitigated within 24 hrs	**Response times:** • Aggravated within 24 hrs • Standard within 48 hrs • Mitigated within 72 hrs	**Response times:** • Aggravated within 48 hrs • Standard within 72 hrs • Mitigated within 72 hrs (excluding weekends and holidays)	**Response times:** • Aggravated within 72 hrs (excluding weekends and holidays) • Standard within 7 consecutive days
Physical abuse: Child death due to physical abuse or neglect or suspicious death; injuries requiring emergency medical treatment; child under the age of 6 observed or reported to be struck in the head, face, neck, genitals, or abdomen which could likely cause injury; child under the age of 24 months is shaken; physical abuse by a parent, guardian, or custodian who has a previous substantiated priority 1 report or who threatens or presents serious bodily harm to the child now.	**Physical abuse:** Injuries that may require medical treatment; priority 3 injury to a child under the age of 6; child 6 years of age or older observed or reported to be struck in the head, face, neck, genitals, or abdomen which could likely cause injury; parent, guardian, or custodian presents serious bodily harm to a child or fears or threatens to harm child if no intervention is received and he or she has a previous substantiated report of physical abuse; child under 3 months of age born to parents whose parental rights have been previously terminated.	**Physical abuse:** Injuries not requiring medical treatment such as cigarette burns, single or small bruises, or injury to buttocks or scalp; parent, guardian, or custodian fears or threatens to harm child if no intervention is received.	**Physical abuse:** Home environment stressors place child at risk of physical abuse which may include domestic violence, mental illness, substance abuse, history of physical abuse with no current injuries, etc.
Sexual abuse: Physical evidence of sexual abuse reported by a medical doctor or child reporting sexual abuse within the past 7 days; child reporting vaginal or anal penetration or oral sexual contact within past 72 hours and has not been examined by a medical doctor.	**Sexual abuse:** Sexual behavior within the past 8 to 14 days; attempted sexual behavior or sexual behavior when last occurrence is unknown or when last occurred beyond 14 days and up to 1 year; parent, guardian or custodian suggests or entices a child to engage in sexual behavior, but there is no actual touching; child is exhibiting physical or behavioral indicators which are consistent with sexual abuse and there are indicators the behavior is caused by a parent, guardian or caretaker; child is living in the home with a person convicted or a sexual offense against a child.	**Sexual abuse:** Parent guardian or custodian sexually abused a child in the past and is now living in a home with a child; attempted sexual behavior or sexual behavior when last occurrence was beyond one year and the perpetrator currently has access to the child.	**Sexual abuse:** NA
Emotional abuse: NA	**Emotional abuse:** Child diagnosed by a qualified mental health professional as exhibiting severe anxiety, depression, withdrawal or untoward aggressive behavior, which could be due to serious emotional damage by a parent, guardian or custodian.	**Emotional abuse:** Parent, guardian, or custodian demonstrates behavior or child reports parent, guardian or custodian behavior which is likely to have the effect of fear, rejection, isolation, humiliation or debasement of a child.	**Emotional abuse:** NA

Appendix: (Concluded)

Priority 1 High Risk	Priority 2 Moderate Risk	Priority 3 Low Risk	Priority 4 Potential Risk
Response times: • Standard within 2 hrs • Mitigated within 24 hrs	**Response times:** • Aggravated within 24 hrs • Standard within 48 hrs • Mitigated within 72 hrs	**Response times:** • Aggravated within 48 hrs • Standard within 72 hrs • Mitigated within 72 hrs (excluding weekends and holidays)	**Response times:** • Aggravated within 72 hrs (including weekends and holidays) • Standard within 7 consecutive days
Neglect: Delayed or untreated medical condition which is life-threatening or permanently disabling; child of any age who is left alone and cannot care for self or for other children due to physical, emotional, or mental instability; child under the age of 6 who is alone now; child 6 to 9 years of age is alone for 3 hours or longer or unknown when parent, guardian or custodian will return; imminent harm to child under the age of 6 due to inadequate supervision by parent, guardian or custodian; neglect results in serious physical injury or illness requiring emergency medical treatment; imminent harm to child due to health or safety hazards in living environment; child assessed as suicidal by qualified mental health professional and parent, guardian or custodian is unwilling to secure needed emergency medical treatment; no parent willing to provide immediate care for a child and child is with caregiver who is unable or unwilling to care for the child now or child is left to his or her own resources; history of extensive gestational substance abuse to child under 3 months of age or mother or child tests positive for non-prescribed or illegal drug or alcohol at time of birth; child under 2 months of age displays non-prescribed or illegal drug or alcohol withdrawal symptoms; mother is using cocaine, heroin, methamphetamines or PCP and is breastfeeding a child.	**Neglect:** Child age 11 to 13 years caring for a child age 6 or younger for 12 hours or longer; living environment presents health or safety hazards to a child under the age of 6 which may include human/animal feces, undisposed garbage, exposed wiring, access to dangerous objects or harmful substances, etc.; sexual conduct or physical injury occurs between children due to inadequate supervision or encouragement by parent, guardian or custodian; no parent willing to care for a child and child is with a caregiver who is unable or unwilling to continue caring for the child less than 1 week; child under 3 months of age born to parents whose parental rights have been previously terminated.	**Neglect:** Delayed or untreated medical problem caused child pain or debilitation that is not life-threatening and parent, guardian, or custodian is unwilling to secure medical treatment; child under the age of 9 who is not alone at the time of the report, but has been left alone within the past 14 days; parent, guardian or custodian demonstrates an inability to care for a child within the past 30 days including leaving a child with inappropriate or inadequate caregivers; living environment presents health or safety hazards to a child 6 years of age or older which may include human/animal feces, undisposed garbage, exposed wiring, access to dangerous objects or harmful substances, etc.; food not provided and child is chronically hungry; significant developmental delays due to neglect; parent, guardian or custodian is not protecting a child from a person who does not live in the home and who abused a child; no parent willing to care for a child and child is with a caregiver who is unable or unwilling to continue caring for the child beyond 1 week up to 30 days; use of a child by a parent, guardian or custodian for material gain which may include forcing the child to panhandle, steal or perform other illegal activities.	**Neglect:** Parent, guardian, or custodian has no resources to provide for child's needs including supervision, food, clothing, shelter and medical care; home environment stressors place child at risk of neglect which may include mental illness, substance abuse, etc.; living environment is likely to present a health or safety hazard to a child; child adjudicated dependent due to a finding of incompetency or not restorable to competency; sexual conduct or physical injury between children and unknown if parent, guardian or custodian will protect; complaint by law enforcement or officer of juvenile court alleging dependency due to a delinquent or incorrigible act committed by a child under the age of 8.

AGENCY RESPONSE

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
1717 W. Jefferson • P.O. Box 6123 • Phoenix, AZ 85005

Janet Napolitano
Governor

David A. Berns
Director

December 14, 2005

Debbie Davenport
Auditor General
Office of the Auditor General
2910 North 44 Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Davenport:

The Department of Economic Security is pleased to provide the following comments to supplement the CPS Investigations Performance Audit conducted by your office.

The rights of children to remain safe and in the care of their parents are among the most fundamental. Child Protective Services protects children by investigating allegations of abuse and neglect, promoting the well-being of children in permanent homes, and coordinating services to strengthen families. The Department takes its mission seriously and appreciates the work of your office in identifying areas of practice requiring improvement, including investigation response time and timely date entry into the case management information system.

The Audit conducted by your office covers a thirty-three month time period, specifically from July 1, 2002 through March 31, 2005. During this almost three year period, our Department's Child Protective Services (CPS) received 91,267 CPS reports and assigned one hundred percent (91,267) of these reports for investigation. As you have acknowledged in your report, there has been a 27 percent increase in the number of reports received and assigned for investigation by CPS (from 29,290 reports in 2003 to 37,170 reports in 2005).

Your office reviewed a computer report that identified cases in the database that were missing two data elements: CPS response time and after investigation findings. Of the 91,267 reports assigned during this period, you found 920 CPS reports, (1 percent of the total number of CPS reports reviewed) that were missing these two data elements. This missing information in the computer system raises questions as to whether investigations had occurred for those reports. Your office selected 15 of those reports, reviewed additional electronic and paper records, and found that 3 of the 15 reports had not been investigated.

To ensure child safety, the Division reviewed the electronic and paper files of all 920 reports and determined that of the 920, an additional eight (8) reports had not been investigated. Investigators were immediately instructed to locate the families involved and complete safety and risk assessments of the children. In all but one case, investigators were able to locate the families and take steps to ensure the children's safety. In the remaining case, the child had turned 18 since the report had been received.

This Audit reinforced for the Department the findings of your office's recent report issued in May 2005, CHILDS Data Integrity Process, which identified the need for more timely CPS data entry into the case management information system. The Department is aggressively pursuing strategies to improve timely data entry, including continual modification of the case management information system to make it more efficient and easier to use and the implementation of a Business Intelligence Dashboard which allows management, supervisors and CPS staff to view collected data, analyze trends, and most importantly, monitor performance. CPS has prioritized the following for the initial data display for this new automated tool: response time for CPS investigations, timeliness of CPS investigations, and timeliness for case manager visitation with children and families.

The Audit also found that many CPS reports were not responded to within the timeframes established by our child welfare policy. Our policy was established to assist CPS supervisors and workers in prioritizing their response to all the CPS reports that have been assigned for investigation. Based upon additional information obtained by CPS, such as from the reporting source, hospital personnel, or law enforcement, CPS may determine that the child is safe and prioritize another CPS report for response, when the safety of that alleged child victim is unknown. This may result in an investigation being considered untimely according to our policy, but better ensures that children are safe.

CPS workers are committed to providing timely and quality investigations. The increased number of CPS reports that have been assigned for investigation over the past several years have impacted investigation timeliness and data integrity. In addition, staff turnover and vacancies have increased caseloads in some offices of the state. The Department is working diligently to implement strategies to improve the recruitment and retention of CPS staff, including participation in the Western Region Recruitment and Retention project headed by the University of Denver.

I have also directed CPS to review our:

- Quality Assurance processes to ensure that the CPS investigation process, including timeliness of initiating investigations, completion of after-investigation findings, and thoroughness of investigation, are reviewed and assessed on an ongoing basis.

- District tools used to monitor investigation status to ensure all areas of key activity are being captured until all elements can be tracked automatically in the Business Intelligence Dashboard.

We are committed to continued practice improvements, particularly as to data integrity, retention of CPS staff and supervisors, and the quality and availability of CPS training. All of these efforts will improve our investigation practice and documentation of those investigations in the case management information system.

We are providing an attachment which addresses our plans for implementing the recommendations suggested by your office. Please feel free to contact me at (602) 542-5678, or Tracy Wareing, Acting Deputy Director, Division of Children, Youth and Families, at (602) 542-3598.

Sincerely,

David A. Berns

David A. Berns

Attachment

DEPARTMENT OF ECONOMIC SECURITY
RESPONSE TO AUDITOR GENERAL'S REPORT
CHILD PROTECTIVE SERVICES PERFORMANCE AUDIT
DECEMBER 14, 2005

The Department of Economic Security (Department) is providing the following comments and responses to the finding and recommendations of the Office of the Auditor General's performance audit of Division of Children, Youth and Families' (Division) Child Protective Services (CPS) Investigations.

The rights of children to remain safe and in the care of their parents are among the most fundamental. Child Protective Services protects children by investigating allegations of abuse and neglect, promoting the well-being of children in permanent homes, and coordinating services to strengthen families. The Department takes its mission seriously and appreciates the work of the Auditor General in identifying areas of practice requiring improvement, including investigation response time and timely date entry into the case management information system.

Because audits may guide public policy discussions and decisions, it is important to understand the full context of the total number of CPS reports that were received and assigned for investigation during this review period. The Auditor General conducted an audit that covers a thirty-three month time period, specifically from July 1, 2002 through March 31, 2005. During this almost three year period, CPS received 91,267 CPS reports and assigned one hundred percent (91,267) of these reports for investigation. CPS was able to complete investigations on over 99.99 percent of these assigned 91,267 reports. As the Auditor General acknowledged, there has been a 27 percent increase in the number of reports received and assigned for investigation by CPS (from 29,290 reports in 2003 to 37,170 reports in 2005).

The Auditor General reviewed a computer report that identified cases in the database that were missing two data elements: CPS response time and after investigation findings. The Auditor General found 920 CPS reports, 1 percent of the total number of CPS reports reviewed, that were missing these two data elements and questioned whether investigations had occurred for those reports. Based upon that finding, the Auditor General selected 15 of those reports, reviewed additional electronic and paper records, and found that 3 of the 15 reports had not been investigated.

To ensure child safety, the Division reviewed the electronic and paper files of all 920 reports and determined that of the 920, an additional eight (8) reports had not been investigated. Investigators were immediately instructed to locate the families involved and complete safety and risk assessments of the children. In all but one case, investigators were able to locate the families and take steps to ensure the children's safety. In the remaining case, the child had turned 18 since the report had been received.

The Auditor General notes that the Division does not always initiate investigations within the required timeframes. These timeframes were established to assist CPS supervisors and workers in prioritizing CPS reports received and assigned for investigation. The Auditor General found that 54 percent of the CPS investigations were responded to within the required timeframes and 12 percent were not responded to within the required timeframes. The timeliness of the response in the remaining 34 percent of cases could not be determined, although investigations were completed in all those cases. For the cases that were not responded to within the required timeframes, 6,905 or 61 percent were identified as potential or low risk reports; 3,185 or 28 percent missed the timeliness standard by one day or less and an additional 4,185 or 37 percent missed the timeliness standard by 2 to 5 days.

The Division's paramount concern is child safety. CPS supervisors and workers prioritize the order in which CPS reports will be responded to from the information received from the statewide hotline and information about the child's immediate safety received from a variety of sources contacted after the report is received. These include, but are not limited to; the reporting source, which may provide additional information; the hospital, to determine a discharge date for a child that is hospitalized; and, when law enforcement has made the initial response, the officers responding that have information about the child's safety. Although these steps help to ensure child safety, these contacts are not considered the initial CPS response according to the Division's child welfare policy and its database system. If the child is determined safe, these initial actions allow CPS to prioritize other investigations that have been assigned, ones in which child safety cannot be determined through additional contact with others.

Many of the findings in this most recent Auditor General's report mirror findings in the Auditor's May 2005 report on the CHILDS Data Integrity Process. CPS staff are committed to providing timely and quality investigations. The increased number of CPS reports that are assigned for investigation impact investigation timeliness and data integrity. To address the issues raised in the May 2005 audit, the Department has committed to making practice improvements and increasing data integrity. In addition, the Department is pursuing strategies to improve the recruitment and retention of CPS supervisors and workers, and to increasing the quality and availability of CPS training. All of these efforts will improve CPS investigation practice and documentation of those investigations in the case management information system.

One example of these solutions, which will be implemented in January 2006, is the statewide use of a user-friendly on-line reporting tool (Business Intelligence Dashboard) which allows management, supervisors and CPS staff to view collected data, analyze trends, and most importantly, monitor performance from the statewide level down to the worker level The Division has prioritized the following for the initial data display for this new automated tool: response time for CPS investigations, timeliness of CPS investigations, and timeliness for case manager visitation with children and families. Additional data elements will be added after full implementation of this reporting tool.

The Department's specific response to the Auditor General's finding and recommendations follow in the next section.

RESPONSE TO REPORT FINDING AND RECOMMENDATIONS

The Department's response to the Auditor General finding and recommendations includes strategies that the Division is currently implementing or will begin implementing. Many of these strategies include modifications to the Division's case management information system. The Division will begin immediately to pursue the numerous steps necessary to modify an automated system. These modifications will be made on an aggressive schedule in order to implement the agreed upon recommendations of the Auditor General.

Recommendation 1:

To ensure the Division's reported investigation rate accurately reflects investigated reports, the Division should base the rate on the number of CPS reports received that have findings for all allegations and for which the supervisor has reviewed and approved the findings. This will require a modification to the automated case management system to capture supervisor approval of each of the allegation findings.

DES Response 1:

The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

The Division currently reports on the number of communications that meet the criteria of a report and the number of those reports which have been dispositioned (assigned to a case worker) for investigation. The Division will modify the report to include the number of investigations that have been closed. The Division will modify the investigation closure process to require that all the findings of allegations of abuse or neglect be entered into the automated system before the supervisor can approve the closure of the investigation.

Target Completion Date: March 31, 2006

Recommendation 2a:

To ensure the Division can effectively monitor investigation timeliness, it needs to add edits to the case management system to prevent invalid dates being input.

DES Response 2a:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The Division will modify the automated system to ensure the following:

1) The response date cannot precede the communication received date.
2) The investigation cannot be closed unless a response date has been entered.

Target Completion Date: June 30, 2006

In addition, the Division will research what potential modifications can be made to the automated case management system to allow an "unknown" report to be assigned within the automated system and then later merged with a prior case when the names of family members become known. Currently, "unknown" CPS reports are assigned to the CPS worker who initiates the investigation but the CPS report is not assigned in the case management information system until the surname of the family becomes known. This prevents the creation of additional cases on the same family in the case management information system that are not linked to one another. However, this results in invalid dates in the case management information system.

Target Completion Date for Research: February 28, 2006

Recommendation 2b:

To ensure the Division can effectively monitor investigation timeliness, it needs to clarify policy to clearly indicate that it is the CPS investigator's response time that must be recorded in the automated case management system, even if emergency personnel are also involved.

DES Response 2b:

The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

DES agrees that it is the CPS investigator's response time that must be recorded in the automated case management system. In addition, DES believes that it is also important to document when emergency personnel have provided first response and have ensured child safety.

The Division will clarify with CPS staff the policy when they can indicate someone other than CPS conducted the initial response and the subsequent time frame for CPS to initiate their investigation

Target Completion Date: December 31, 2005

In addition, the Division will modify the automated case management information system to allow entry of both the initial CPS response time and the initial response time of emergency personnel, when emergency personnel response has ensured child safety.

Target Completion Date: June 30, 2006

Recommendation 2c:

To ensure the Division can effectively monitor investigation timeliness, it needs to modify the automated case management system to allow the recording of the assignment of a report with an unknown family surname and then later merge it with any prior cases once the family surname becomes known.

DES Response 2c:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The Division will research what potential modifications can be made to the automated case management system to allow an "unknown" report to be assigned within the automated system and then later merged with a prior case when the names of family members become known. Currently, "unknown" CPS reports are assigned to the CPS worker who initiates the investigation but the CPS report is not assigned in the case management information system until the surname of the family becomes known. This prevents the creation of additional cases on the same family in the case management information system that are not linked to one another. However, this results in invalid dates in the case management information system.

Target Completion Date for Research: February 28, 2006

Recommendation 3:

To better ensure the safety and well being of child victims of abuse and neglect, the Division should investigate 100 percent of reports requiring investigation.

DES Response 3:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Recommendation 4:

To improve the usefulness of the investigation closing summary documentation, the Division should ensure investigators document consistent and comprehensive information.

DES Response 4:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The Division will incorporate the CPS supervisor's review of this requirement through the development and implementation of an "investigation case closure" template. This template will contain all the necessary elements the CPS supervisor needs to review prior to investigation case closure, including documentation of consistent and comprehensive information.

Target Completion Date for Template Implementation: January 31, 2006

Recommendation 5a:

To better ensure investigative performance is timely and thorough, the Division should establish three to five priorities that are most important to the investigative function and would demonstrate that the Division is performing efficiently and focus on these areas.

DES Response 5a:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Based up the Auditor General's recommendation, the Division established and set the following priorities: Response Timeliness, Investigation Completion, and Documentation.

The first two priorities are key performance indicators that are in the Business Intelligence Dashboard. The Business Intelligence Dashboard will record an investigation as completed when all the allegation findings are entered. The third priority, documentation, is addressed within the Division's response to the Auditor General's number 4 recommendation.

Target Completion Date: January 31, 2006

The Division will continue to look for opportunities to better ensure timely and thorough investigations.

Recommendation 5b:

To better ensure investigative performance is timely and thorough, the Division should develop and use additional management reports or other mechanisms to keep Division administration apprised of investigative performance in the established priority areas so that timely corrective action can be taken if needed.

DES Response 5b:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The Division has taken the following steps to improve the development and use of management tools to monitor performance:

- The Division is implementing a user-friendly on-line reporting tool (Business Intelligence Dashboard) which will allow management, supervisors and CPS staff to view collected data, analyze trends, and most importantly, monitor performance. The Division has prioritized the following for the initial data components for this new automated tool: response time for CPS investigations, timeliness of CPS investigations, and timeliness for case manager visitation with children and families. This new tool will be available in January 2006, and will portray data on a statewide, district, unit, and individual worker basis.

- In October 2005, the Division initiated monthly learning sessions with the Practice Improvement Specialists (including Central Office and District staff), District Automation Liaisons (DALs), Division Reports & Statistics staff, the Program Administrator for Finance and Business Operations, and the District Program Managers to train staff on the use of data. The initial training was provided by the National Resource Center for Child Welfare Data and Technology and the National Resource Center for Organization Improvement on October 6th & 7th. The focus of the first learning session was to develop a baseline of knowledge and understanding around child welfare data. The second session occurred on November 16, 2005 and focused on some of the current reports which are

distributed to the Districts, including exception reports. One of the goals of these sessions is to develop the knowledge and expertise of the staff whose responsibility it is to use data and management reports to inform and monitor practice.

- Case Reviews are completed on a random sample of cases in each district to monitor performance based upon the federal Child and Family Service Review. This review includes timeliness of investigations and other critical functions. After each district review, the findings are reviewed with Division and District staff. The Case Review mirrors the federal Child and Family Service Performance measures and identifies the percentage of investigations initiated within state policy timeframes. These reviews have not identified any uninvestigated reports.

The Division will continue to implement the above strategies and look for other opportunities to monitor CPS performance.

Recommendation 5c:

To better ensure investigative performance is timely and thorough, the Division should hold staff accountable for achieving the Division's priorities and expectation by requiring the Division's personnel unit to implement a centralized tracking system to record when staff evaluations are due and conducted and each person's overall performance rating so that management can readily identify those workers in need of corrective action.

DES Response 5c:

The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

DES concurs that the timely completion of performance evaluations (ESTEEM) for staff is a critical component of management. Unfortunately, there is no automated system that can generate reports to identify which staff have past due ESTEEMs or which staff have upcoming ESTEEMs. DES is working with the Department of Administration (ADOA) to determine if it is possible to establish an interface between the ADOA Human Resource Information System (HRIS) and the DES Financial Management Control System (FMCS) Data Warehouse to generate these reports. DES understands that ADOA is also exploring an automated tracking system for PASE which is the staff evaluation format being used by ADOA and most other state agencies. If that evaluation process can be automated more easily and quickly than developing an interface for HRIS and FMCS, DES would prefer to change to the PASE evaluation process, rather than developing a duplicate staff evaluation tracking system.

Recommendation 6:

Because of the negative impact that untimely, inaccurate, and incomplete documentation can have on a child's continued safety and well-being, as well as an investigator's ability to investigate CPS reports and substantiate allegations of abuse and neglect where appropriate, Division management should communicate the importance of recording timely, accurate, and complete documentation in the automated case management system.

DES Response 6:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The Division will continue to communicate the importance of accurate and timely case documentation. During initial case manager core training, accurate and timely case documentation is trained and the importance emphasized.

The Division will send a reminder to CPS staff regarding the importance of recording timely, accurate, and complete documentation in the automated case management system.

Target Completion Date: December 16, 2005

The Division will develop and distribute documentation guides for CPS supervisors and workers.

Target Completion Date: February 15, 2006

The Division will develop and implement an advanced training class on documentation. All CPS supervisors and workers will be required to attend this training.

Target Completion Date Curriculum Development: February 28, 2006

CPS Performance Audits and Information Briefs Issued

CPS Performance Audits		Information Briefs	
CPS-0501	CHILDS Data Integrity Process	IB-0401	Federal IV-E Waiver Demonstration Project Proposal
		IB-0501	Family Foster Homes and Placements
		IB-0502	Revenue Maximization

Future CPS Performance Audits

Training

Future CPS Information Briefs

Types of Federal Monies Available