

Special Audit

Arizona Department of Child Safety

Investigations of Reports Involving Child Welfare Agency (Group Home) Staff

Department's reported process for determining to remove group home staff's access to children while under investigation for child abuse does not fully address potential safety threats to children, and its lack of explicit statutory authority to place group home staff on the central registry for neglect risks that some neglect perpetrators continue working with children



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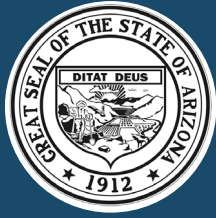
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ARIZONA AUDITOR GENERAL

Lindsey A. Perry, Auditor General

September 23, 2026

Members of the Arizona State Legislature

The Honorable Katie Hobbs, Governor

Director Ptak
Arizona Department of Child Safety

Transmitted herewith is a report of the Auditor General, *A Special Audit of the Arizona Department of Child Safety—Investigations of Reports Involving Child Welfare Agency (Group Home) Staff*. This report is in response to a September 18, 2024, resolution of the Joint Legislative Audit Committee. I am also transmitting within this report a copy of the Report Highlights to provide a quick summary for your convenience.

As outlined in its response, the Department agrees with all the findings and plans to implement all the recommendations. My Office will follow up with the Department in 6 months to assess its progress in implementing the recommendations. I express my appreciation to Director Ptak and Department staff for their cooperation and assistance throughout the audit.

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

Sincerely,

Lindsey A. Perry

Lindsey A. Perry, CPA, CFE
Auditor General

Arizona Department of Child Safety

Special Audit—Investigations of Reports Involving Child Welfare Agency (Group Home) Staff

Department's reported process for determining to remove group home staff's access to children while under investigation for child abuse does not fully address potential safety threats to children, and its lack of explicit statutory authority to place group home staff on the central registry for neglect risks that some neglect perpetrators continue working with children

Audit purpose

To review the Department's processes for initiating and conducting investigations of child abuse involving Department-licensed and contracted group home staff.¹

Key findings

- ▶ Effective September 2024, Laws 2024, Chapter 47, revised statute to authorize and require the Department to investigate reports of child abuse that include allegations of child abuse committed by staff who work in Department-licensed and contracted group homes, but it did not revise the statutory definition of neglect to include group home staff actions.
- ▶ Department's reported process of assessing child safety prior to determining to remove group home staff's access to children while under investigation for alleged child abuse did not fully address potential safety threats to children and risks to the investigative process for between 1.5 hours to up to 5 days for reports we reviewed.
- ▶ Because Laws 2024, Chapter 47, did not revise the statutory definition of neglect to include group home staff actions, the Department lacks explicit statutory authority to place group home staff on the central registry for child neglect, risking that some child neglect perpetrators could continue working with children.

Key recommendations to the Department

- ▶ Develop policies and procedures for making and documenting decisions to remove group home staff's access to children while under investigation for alleged child abuse.
- ▶ Consider pursuing statutory changes to clarify its authority to investigate reports of alleged child neglect by group home staff.

¹ The Arizona Auditor General conducted this special audit of the Department pursuant to a September 18, 2024, resolution of the Joint Legislative Audit Committee.

INTRODUCTION

1

- ▶ Department is responsible for investigating reports of child abuse and neglect
- ▶ Department is the legal custodian responsible for the well-being of children placed in its care
- ▶ Effective September 2024, statute was revised requiring the Department to also investigate reports of child abuse allegations involving group home staff
- ▶ As of March 2026, there were 172 Department-licensed and contracted group homes, and approximately 1,200 children in Department care resided in group homes
- ▶ Department policies outline requirements for Department staff to respond to and investigate allegations of child abuse involving group home staff as the alleged perpetrator
- ▶ Department received 54,578 reports of child abuse and neglect between September 14, 2024 and December 1, 2025, and 93 of those reports alleged child abuse by group home staff
- ▶ Department has 80 investigators who investigate child abuse reports involving group home staff, and 83% of investigator positions were filled as of March 2026
- ▶ JLAC resolution directed us to assess Department's processes for investigating reports of child abuse and neglect and consider various potential audit questions related to these processes

CHAPTER 1

13

Although our review did not identify systemic child safety or investigative process failures, Department's reported process for determining if it should remove group home staff under investigation for alleged abuse from having access to children does not fully address potential safety threats to children in group homes and risks to the investigative process

- ▶ Department reported that it determines whether or not to remove group home staff under investigation for abuse from having access to children after assessing child safety
- ▶ Issue 1: Department did not follow up with 2 nonresponsive group homes for reports we reviewed to ensure they removed alleged perpetrators' access to children as it had directed, and 1 alleged perpetrator was later alleged to have abused another child in a second group home while under Department investigation

- ▶ Issue 2: Department’s practice of interviewing the alleged child victim before determining whether to remove alleged perpetrators’ access to children in group homes resulted in it not fully resolving potential safety threats to children and risks to the investigative process for 1.5 hours up to approximately 5 days for reports we reviewed
- ▶ Issue 3: Department lacks written policies, procedures, or guidance outlining its process for making and documenting decisions to remove alleged perpetrators’ access to children in group homes, which may lead to inconsistent and inappropriate decisions
- ▶ Issue 4: Department contracts do not include written requirements outlining Department expectations for child welfare agencies regarding group home staff’s access to children while under investigation, increasing the risk that group homes will act inconsistently and/or inappropriately

Recommendations to the Department	19
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CHAPTER 2	20
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Department lacks explicit statutory authority to place group home staff on the central registry for child neglect and instead reviews neglect allegations as potential licensing violations, risking that child neglect perpetrators can continue working with children unless otherwise prohibited by a criminal arrest, trial, or conviction

Recommendations to the Department	22
--	-----------

SUMMARY OF RECOMMENDATIONS	23
-----------------------------------	-----------

The Arizona Auditor General makes 7 recommendations to the Department

APPENDIX A	a-1
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Summary information about Department time to contact alleged child victims for 14 of 26 sampled reports with group home staff as the alleged perpetrator

APPENDIX B	b-1
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Scope and methodology

DEPARTMENT RESPONSE	
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FIGURE

▶ Figure 1	4
As of March 2026, Department licensed and contracted 172 group homes in 6 counties	

TABLES

▶ Table 1	9
All 93 reports involving group home staff as the alleged perpetrator the Department received between September 14, 2024 and December 1, 2025, occurred in 3 counties	
▶ Table 2	9
Department had 17 vacant investigator and investigation supervisor positions that investigate abuse reports involving group home staff as of March 2026	
▶ Table 3	a-2
Department investigators took between 1 hour and 23 minutes and approximately 5 days to assess child safety in 14 reports we reviewed	

INTRODUCTION

The Arizona Auditor General has released the second report in a series of 3 special audit reports on the Arizona Department of Child Safety's (Department) processes for initiating and conducting investigations of reports of child abuse and neglect, pursuant to a September 18, 2024, resolution of the Joint Legislative Audit Committee (JLAC). The first special audit assessed whether the Department investigated noncriminal child abuse and neglect reports as required by statute and Department policy.¹ This special audit assessed whether the Department investigated reports involving staff who work at Department-licensed child welfare agencies, as required by statute and Department policy (see key terms textbox for a definition of child welfare agency). The third and final special audit will review the Department's processes for initiating and conducting investigations of child abuse and neglect reports involving allegations of criminal conduct.

Key terms

Child welfare agency: An organization licensed by the Department to receive and care for children in a group home or shelter.¹

Group home: A residential facility to provide children 24-hour supervision in a group care setting.

Shelter: A group care setting that is available for a child in need of immediate placement.

¹ Child welfare agencies do not include State-operated institutions or facilities, juvenile detention facilities, or healthcare institutions licensed by the Arizona Department of Health Services.

Source: Auditor General staff review of rule, statute, and Department website and policies.

Department is responsible for investigating reports of child abuse and neglect

Arizona Revised Statute (A.R.S.) §8-451 establishes the Department with the primary purpose to protect children in Arizona, and the Department is statutorily responsible for investigating reports of alleged child abuse and neglect (see textbox, page 2, for a description of the types of reports the Department is responsible for investigating).^{2,3,4}

¹ See Arizona Auditor General report 25-109 *Arizona Department of Child Safety—Investigations of Noncriminal Child Abuse and Neglect Reports*.

² Laws 2014, 2nd S.S., Ch. 1, §20, established the Department, effective May 2014. Prior to the Department's establishment, the State's child welfare functions were conducted by Child Protective Services within the Department of Economic Security's Division of Children, Youth, and Families, which was terminated by a Governor executive order in January 2014.

³ Pursuant to A.R.S. §8-201(2), abuse is the infliction or allowing of physical injury, impairment of bodily function or disfigurement, or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior and which is diagnosed by a medical doctor or psychologist and is caused by the acts or omissions of an individual who has the care, custody, and control of a child. Abuse includes inflicting or allowing sexual abuse, sexual assault, child sex trafficking, or other sexual exploitation of a child; physical injury resulting from allowing a child to enter or remain in a structure or vehicle with toxic chemicals or equipment for the purpose of manufacturing dangerous drugs; and unreasonable confinement of a child.

⁴ Pursuant to A.R.S. §8-201(25), neglect is the inability or unwillingness of a parent, guardian, or custodian of a child to provide that child with supervision, food, clothing, shelter, or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, except if the inability to provide services to meet the needs of a child with a disability or chronic illness is solely the result of the unavailability of reasonable services; allowing a child to enter or remain in a structure or vehicle with toxic chemicals or equipment for the purpose of manufacturing dangerous drugs; a determination by a health professional that a newborn was exposed prenatally to certain drugs or substances and the exposure was not the result of a medical treatment administered to the mother or newborn; a diagnosis by a health professional of an infant with fetal alcohol syndrome or fetal alcohol effects; deliberate exposure of a child to sexual conduct or explicit sexual materials; and the committing of sexual acts with reckless disregard as to whether the child is physically present.

Pursuant to A.R.S. §§8-455 and 8-456, the Department is required to:

- ▶ Operate a centralized hotline for the public to report alleged child abuse and neglect.⁵
- ▶ Investigate reports of child abuse and neglect.
- ▶ Determine the nature, extent, and cause of any condition that supports or refutes an allegation that the child is a victim of abuse or neglect.

Department classifies and investigates reports alleging child abuse and neglect as criminal and noncriminal

According to Department policy and procedures and pursuant to A.R.S. §8-455(G), the Department classifies and investigates reports alleging a child was abused or neglected as either criminal or noncriminal.¹

Criminal—Investigations of reports alleging criminal conduct can include allegations such as:^{2,3}

- Threat to a child with a deadly weapon, such as a pipe, firearm, or knife.
- Sexual abuse and/or sexual exploitation of a child, including sex trafficking.
- Untimely death of a child, excluding alleged suicides, unless the alleged suicide involved a firearm.
- Nonaccidental or unexplained serious injuries, such as burns and substantial bruising.

Noncriminal—Investigations of reports alleging noncriminal conduct can include allegations such as:

- Living environment is a threat to a child's safety.
- Verbal threats to a child made without a weapon in hand.
- Not protecting a child from child-on-child sexual contact.

¹ According to A.R.S. §8-455, the suspected child victim must be a resident of the State or present in the State.

² As discussed on page 1, we will review the Department's practices for investigating criminal child abuse and neglect allegations in our third special audit report, due September 30, 2026.

³ A.R.S. §8-201(8) defines a criminal conduct allegation as an allegation of conduct by a parent, guardian, or custodian of a child or an adult member of the victim's household that, if true, would constitute a felony offense that constitutes domestic violence as defined in A.R.S. §13-3601; a violation of A.R.S. §13-3623 involving child abuse, A.R.S. §§13-1404 or 13-1406 involving a minor, or A.R.S. §§13-1405, 13-1410, or 13-1417; an offense that constitutes domestic violence as defined in A.R.S. §13-3601 and that involves a minor who is a victim of or was in imminent danger during the domestic violence; or any other act of abuse that is classified as a felony.

Source: Auditor General staff review of Department policies and procedures for child abuse and neglect investigations and A.R.S. §§8-201 and 8-455.

⁵ A.R.S. §8-455 requires the Department to operate a centralized hotline all hours every day to receive allegations of child abuse and neglect. Department hotline staff are responsible for receiving the allegations and determining if the information in the allegation meets the statutory criteria for a report, the priority level of the report, and whether the report contains criminal or noncriminal allegations.

Department is the legal custodian responsible for the well-being of children placed in its care

The Department is responsible for overseeing the placement and managing the cases of children who have been adjudicated dependent by the juvenile court and placed under the Department's legal custody while in out-of-home care, including placements with Department-licensed and contracted group homes.⁶ For example, the Department is responsible for providing these children with services. Although Department-licensed and contracted group homes and their staff are responsible for meeting the day-to-day physical, emotional, and educational needs of children in group homes, the Department remains legally responsible for the care, custody, control, and well-being of the children it places in group homes.

Effective September 2024, statute was revised requiring the Department to also investigate reports of child abuse allegations involving group home staff

As discussed in our September 2023 performance audit of the Department, the Department reported that as of June 30, 2023, it had stopped investigating allegations of abuse involving child welfare agency/group home staff because it determined that they did not meet the statutory definition of caregiver, and therefore those allegations needed to be investigated by law enforcement or as a licensing concern.⁷ Effective September 14, 2024, Laws 2024, Chapter 47, §§1 and 2, revised the statutory definition of child abuse in A.R.S. §8-201 to include actions by staff who work at group homes and shelters (group homes) operated by a Department-licensed child welfare agency and requires Department hotline staff to prepare a report of child abuse for the Department to investigate if the alleged perpetrator is an employee of a Department-licensed and contracted child welfare agency and is alleged to have abused a child placed with such agency (see pages 4 through 8 for more information about the Department's process for its hotline and its process for receiving and investigating reports of child abuse). These statutory changes both authorized and required the Department to investigate reports alleging child abuse perpetrated by group home staff.

Laws 2024, Chapter 47, did not similarly revise the statutory definition of neglect to include actions perpetrated by group home staff. However, according to the Department, the Department's Office of Licensing and Regulation (licensing office) is required to review concerns involving group home staff that could be considered neglect to determine whether a licensing violation occurred and take action as needed (see Chapter 2, pages 20 through 22, for potential risks we identified related to this issue).

⁶ Pursuant to A.R.S. §8-201(15), dependent children include those whose parents or guardians are unwilling or incapable of exercising parental care and control, and children whose home is unfit because of abuse, neglect, cruelty, or depravity by a parent or any other person having custody or care of the child.

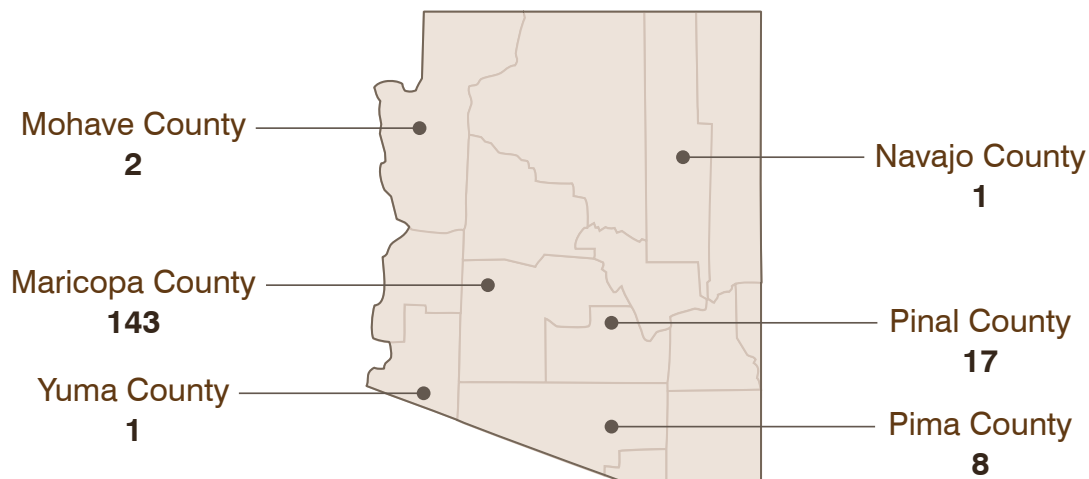
⁷ See Arizona Auditor General report 23-113 *Arizona Department of Child Safety—Licensed Foster Care Oversight*.

As of March 2026, there were 172 Department-licensed and contracted group homes, and approximately 1,200 children in Department care resided in group homes

According to the Department, as of March 2026, there were 172 group homes in the State licensed and contracted by the Department. As shown in Figure 1, these group homes were in 6 counties, with most group homes located in Maricopa County. Additionally, according to the Department's April 2026 *Monthly Operational and Outcome Report*, as of March 2026, 1,220 children in Department care resided in group homes.^{8,9}

Figure 1

As of March 2026, Department licensed and contracted 172 group homes in 6 counties



Source: Auditor General staff review of Department-provided data.

Department policies outline requirements for Department staff to respond to and investigate allegations of child abuse involving group home staff as the alleged perpetrator

The Department has developed policies and procedures to help its staff comply with federal and State laws that govern the Department.¹⁰ Department policies, procedures, and/or guidance for conducting investigations require investigators to (1) complete and document various steps intended to protect children during the investigation process, (2) assess child safety, and (3) obtain sufficient evidence to determine whether to substantiate an allegation of child abuse.^{11,12}

⁸ According to the Department's April 2026 *Monthly Operational and Outcome Report*, some children in Department care who resided in group homes as of March 2026 were in group homes for persons with developmental disabilities that are licensed by the Arizona Department of Health Services and certified to provide services for individuals with developmental disabilities by the Arizona Department of Economic Security's Division of Developmental Disabilities.

⁹ According to the Department's April 2026 *Monthly Operational and Outcome Report*, in addition to the 1,220 children in group homes, 14 children were in shelters (see textbox, page 1, for more information about shelters).

¹⁰ According to the Department, it updates its policies and procedures on an ongoing basis to respond to new or revised federal and State laws, changes in accepted standards of practice, and State initiatives.

¹¹ Department policy requires investigators to document all communications, required documents, notes, and contacts for child abuse investigations in the Department's case-management system within 10 days that the related activity occurred, and Department policies require all documentation to be complete, accurate, and current.

¹² Department policy generally refers to its staff as specialists, and investigative specialists (investigators) are 1 type of Department specialist.

Key requirements in the Department's process to investigate reports involving group home staff include:

- ▶ **Hotline staff required to determine if communications regarding suspected child abuse meet the statutory definition of a report the Department must investigate and if the alleged perpetrator is a group home staff member**

The Department's hotline staff are responsible for determining if communications regarding suspected child abuse meet the statutory criteria to be a report and if the alleged perpetrator is an employee of a group home.¹³ If the communication meets the statutory criteria to be a report, A.R.S. §8-455 requires the Department to investigate it.¹⁴ The date and time that the determination is made is the report's receipt date/time, beginning the investigation.

- ▶ **Hotline staff required to assign priority levels to reports of alleged abuse**

The Department's hotline staff are responsible for assigning priority levels to each report based on the type and severity of the child abuse (see textbox, page 6, for descriptions of the Department's priority levels for abuse reports).¹⁵ After prioritization, the hotline staff then assign the report to 1 of the Department's investigative units for investigation (see page 9 for more information about the Department's investigators for reports involving group home staff).¹⁶

- ▶ **Investigators must gather background information**

Department policy requires that investigators must gather background information, such as obtaining and reviewing background checks and prior allegations for the alleged perpetrator and alleged child victim's medical and school records.

- ▶ **Investigators required to make reasonable efforts to contact the child victim in person at their known or probable location within specific time frames**

Department policy requires investigators to make efforts to contact the child victim in person within specified time frames established in Department policy (see textbox, page 6, for investigator response time frames by priority level).¹⁷ Department efforts to contact the child victim can include visits to the child's home or school.

¹³ Per A.R.S. §8-455, an allegation must meet the following criteria to become a report: the suspected victim is under 18 years old; the suspected conduct would constitute abuse or neglect by the victim's parent, guardian, custodian, or an adult member of the victim's household; the suspected victim is a resident of or present in Arizona; and the identity or current location of the child victim, the child's family, or alleged perpetrator is known or can be reasonably ascertained. Further, hotline staff must prepare a report if the identity of the person suspected of abuse is an employee of a child welfare agency and both of the following apply: the child victim is placed with the agency and the agency is licensed by and contracted with the Department. According to Department policy, if an allegation does not meet the criteria to become a report, the hotline staff should inform the reporting source that the information they provided did not meet the criteria to be a report and document the communication in the Department's case-management system. Additionally, according to Department policy, every 3 days, a hotline supervisor should review communications concerning child abuse or neglect that did not meet the criteria to be a report to verify that the communication was properly classified.

¹⁴ Statute only requires the Department to investigate allegations of abuse against group home staff who work for a group home licensed by and contracted with the Department. Statute does not establish a similar requirement related to staff who work at group homes licensed by the Arizona Department of Health Services.

¹⁵ Hotline staff will also determine whether the allegation(s) includes issues of criminal conduct, and if so, they mark the report as involving criminal conduct.

¹⁶ Hotline staff generally assign criminal reports to the Department's Office of Child Welfare Investigations for a criminal conduct investigation.

¹⁷ The Department has an after-hours investigation team that may make initial contact for reports received outside of business hours, such as the weekend, depending on the report's priority level.

Department policy outlines priority levels and required response time frames for child abuse reports

The Department is statutorily required to identify the priority level of all reports of alleged child abuse, including but not limited to those involving group home staff as the alleged perpetrators.¹ Department policy establishes priority levels for all reports of alleged child abuse and requires investigators to respond with in-person contact/attempted contact with the child victim within specific time frames.

Description of abuse reports by priority level and the required response time frames according to Department policies and procedures that could involve a group home staff member as the alleged perpetrator are as follows:^{2,3}

▶ **Priority 1 (2-hour response time)**

A criminal or noncriminal report alleging death, near fatality, or other serious injury to a child, or that a child may be the victim of sexual abuse.

▶ **Priority 2 (48-hour response time)**

Any criminal report alleging abuse not labeled as a priority 1, any noncriminal report alleging abuse of a child under 3 years old, or an allegation in which the alleged perpetrator or vulnerable child are the subject of a prior report.⁴

▶ **Priority 3 (72-hour response time)**

A noncriminal report alleging abuse of a child within the 12 months preceding the report.

▶ **Priority 4 (7-day response time)**

A noncriminal report alleging abuse of a child more than 12 months prior to the report.

According to A.R.S. §8-455(F), the Department is not required to investigate a noncriminal report if all the following apply: (1) the suspected conduct occurred more than 3 years before the communication to the hotline and (2) there is no information or indication that a child is currently being abused or neglected.

¹ A.R.S. §8-455(B)(4) requires the Department to determine the appropriate priority level based on the report-screening assessment. According to Department policies and procedures, hotline staff use the report-screening assessment to determine the appropriate priority level based on the allegation information.

² Department policy establishes initial response time frames.

³ Department policies and procedures also outline other report allegations and associated priority levels that apply to parents, guardians, and/or custodians. See Arizona Auditor General report 25-109 *Arizona Department of Child Safety—Investigations of Noncriminal Child Abuse and Neglect Reports*, page 5, for more information about abuse and neglect reports by priority level.

⁴ According to Department guidance, a vulnerable child includes a child who is under 5 years old, has diminished mental or physical capacity, has medical or emotional needs, or lacks visibility in the community such as through school or daycare.

Source: Auditor General staff review of Department policies, procedures, and written guidance for child abuse and neglect investigations and A.R.S. §8-455.

► **Investigators must interview alleged child victim(s), all other children living in the group home, alleged perpetrators, and other group home staff in the home**

Department policy requires investigators to interview alleged child victim(s), all other children living in the group home, alleged perpetrator(s), and other staff at the group home.^{18,19} The investigator must document evidence of the interviews in the Department's case-management system.

► **Investigators must gather and review any relevant information that may help substantiate or refute the allegation(s)**

Department policy requires investigators to gather and review any relevant information that may help substantiate or refute the allegation(s), such as the group home's policies and procedures, videos, medical or behavioral health notes, licensing records, or alleged perpetrator's employee file.

► **Investigators must determine investigation findings within 45 days of report receipt, as required by statute**

Investigators must submit their written investigation findings into the Department's case-management system within 45 days of receipt of the report, as required by A.R.S. §8-456.^{20,21} The investigator must either request to propose to substantiate the allegations, unsubstantiate the allegations, or determine that the Department is unable to locate the child victim (see textbox, page 8, for key investigative finding terms).²²

¹⁸ When interviewing the alleged perpetrator, the investigator must provide them with the Notice of Duty to Inform, which includes the specific allegations made against them and their rights while under investigation. According to A.R.S. §8-471(E)(8) for criminal reports, the investigator is required to provide the individual with the allegation the Department received but is not required to disclose details or information that would compromise an ongoing criminal investigation.

¹⁹ Investigators may also interview collateral contacts, which may include individuals likely to have relevant and reliable information such as the child's assigned Department caseworker, medical professionals, or individuals who have regular contact with the child and can describe their day-to-day functioning.

²⁰ The Child Welfare League of America (CWLA), a coalition of public and private agencies whose mission is to advance equity through policies and practices that ensure the well-being of children, youth, families, and communities, found that the Department's 45-day time frame for entering investigation findings into its case-management system is consistent with time frames in 30% of other U.S. states. Further, according to CWLA, 95% of other states have time frame requirements for similar investigation steps that range between 30 and 60 days, with 40% of those states maintaining a 30-day requirement, 30% maintaining a 45-day requirement, and 25% maintaining a 60-day requirement. CWLA further found that the 45-day investigative time frame in child welfare is designed to optimize the balance between rapid child safety decisions and adherence to procedural fairness for families, and the Department's policy appears to strike a balance between putting too much pressure on workers to move quickly and having too much time to let families linger without a decision. See Arizona Auditor General report 25-109 *Arizona Department of Child Safety—Investigations of Noncriminal Child Abuse and Neglect Reports*, page 40, for more information.

²¹ Consistent with statute, Department policy requires investigators to enter their written investigation findings into the Department's case-management system within 45 days.

²² According to Department policy, for reports where the investigator requests to propose to substantiate the allegations, supervisors have 1 day to approve or modify the investigator's submitted investigation findings. The Department reported that once the supervisor approves the request, the finding status is changed to proposed to substantiate. Based on our review of the Department's case-management system, the Department's case-management system does not automatically approve the investigator's findings if the supervisor misses their 1-day deadline.

Key investigative finding terms

Proposed to substantiate: Used when the evidence gathered throughout the investigation supports an incident of abuse or neglect occurred.

Unsubstantiate: Used when the evidence gathered throughout the investigation does not support an incident of abuse or neglect occurred.

Unable to locate: Used if the child victim cannot be located despite reasonable efforts and there is insufficient evidence to conclude abuse or neglect occurred without interviewing or observing the child.

Source: Auditor General staff review of Department policies and procedures for child abuse and neglect investigations.

► **Investigators must make efforts to close the investigation within 60 days of the Department's receipt of the abuse or neglect reports and must notify the alleged perpetrator of the investigation finding once the investigation is closed**

Investigators must make efforts to close the investigation within 60 days of receipt of the report, as required by Department policy.²³ The investigator must also notify the alleged perpetrator of the investigation finding determination once the investigation is closed by providing them with an official notice of proposed substantiation or unsubstantiated, according to Department policy, as well as provide the notice of investigation closure to its unit that licenses and monitors group homes.^{24,25}

Department received 54,578 reports of child abuse and neglect between September 14, 2024 and December 1, 2025, and 93 of those reports alleged child abuse by group home staff

According to Department case-management system data, the Department received 54,578 reports of child abuse and neglect between September 14, 2024 and December 1, 2025. As shown in Table 1, page 9, according to Department case-management system data, the Department received 93 reports alleging child abuse perpetrated by group home staff between September 14, 2024 and December 1, 2025.^{26,27}

²³ The Department's policy does not define "make efforts."

²⁴ The Department's policy does not establish a time frame for providing this notification.

²⁵ This notification includes the investigation summary and recommendations for the Department's licensing unit to review.

²⁶ As discussed in our September 2023 performance audit that reviewed whether the Department investigated and resolved licensing complaints against and conducted monitoring of licensed child welfare agencies consistent with State law and best practices, the Department reported that as of June 30, 2023, it had stopped investigating allegations of abuse against child welfare agency/group home staff because it determined that they did not meet the statutory definition of caregiver, and therefore, those allegations needed to be investigated by law enforcement (see Arizona Auditor General report 23-113 *Arizona Department of Child Safety—Licensed Foster Care Provider Oversight*, pages 3 through 4, for more information).

²⁷ Laws 2024, Chapter 47, §1, did not similarly revise the statutory definition of neglect to include actions perpetrated by group home staff. According to the Department, the Department's licensing unit is required to review concerns against group home staff that could be considered neglect to determine whether a licensing violation occurred and take action as needed.

Table 1

All 93 reports involving group home staff as the alleged perpetrator the Department received between September 14, 2024 and December 1, 2025, occurred in 3 counties

Allegation classification	Number of child abuse reports by county			Total
	Maricopa	Pima	Pinal	
Noncriminal ¹	41	5	16	62
Criminal ²	24	1	6	31
Total	65	6	22	93

¹ The 62 noncriminal reports of child abuse involving group home staff as the alleged perpetrators were assigned a priority 3.

² The 31 criminal reports of child abuse involving group home staff as the alleged perpetrators included 8 priority 1 reports and 23 priority 2 reports.

Source: Auditor General staff review of Department case-management system data.

Department has 80 investigators who investigate child abuse reports involving group home staff, and 83% of investigator positions were filled as of March 2026

The Department has 2 investigative units in its licensing office that investigate noncriminal allegations made against out-of-home caregivers, including group home staff, and the Department’s Office of Child Welfare Investigations (OCWI) investigates allegations against group home staff involving criminal conduct in Maricopa, Pima, and Pinal Counties.^{28,29,30} According to the Department, as of March 2026, approximately 17% of its 96 investigator positions that investigate reports involving group home staff were vacant (see Table 2 for more information on the total number of filled and vacant positions as of March 2026).

Table 2

Department had 17 vacant investigator and investigation supervisor positions that investigate abuse reports involving group home staff as of March 2026

Investigative unit	Investigator positions			Supervisor positions		
	Filled	Vacant	Vacancy rate	Filled	Vacant	Vacancy rate
Licensing office	13	1	7%	2	0	0%
OCWI	67	15	18%	13	1	7%
Total	80	16	17%	15	1	6%

Source: Auditor General staff review of Department-provided staffing information as of March 2026.

²⁸ Out-of-home caregivers also include foster parents.

²⁹ The Department’s out-of-home caregiver investigators and supervisors are located in Phoenix and Tucson, and its OCWI investigators and supervisors are located in Maricopa, Pima, and Pinal Counties.

³⁰ As discussed on page 1, our third special audit will review the Department’s processes for initiating and conducting investigations of child abuse and neglect reports involving allegations of criminal conduct.

JLAC resolution directed us to assess Department's processes for investigating reports of child abuse and neglect and consider various potential audit questions related to these processes

The September 18, 2024, JLAC resolution directed us to assess the Department's processes for initiating and conducting investigations of reports of child abuse and neglect to be completed as multiple audit reports and indicated we could consider various potential audit questions related to these processes.

Pursuant to this resolution, the audit report answered the following questions:

► What are the different types of child abuse and neglect investigations involving group home staff as the alleged perpetrator that the Department conducts?

The Department conducts investigations of criminal and noncriminal allegations of child abuse involving group home staff. Specifically, according to Department policy and procedures and pursuant to A.R.S. §8-455(G), the Department classifies and investigates reports alleging a child was abused by group home staff as either criminal or noncriminal (see page 2 for more information on criminal and noncriminal reports). According to the Department, it is not authorized to conduct investigations of reports alleging neglect perpetrated by group home staff but will determine if the alleged action constitutes a licensing violation (see Chapter 2, pages 20 through 22, for how the Department handles allegations of neglect). During this audit, we reviewed the Department's investigations of reports alleging child abuse perpetrated by group home staff (see Chapter 1, pages 13 through 19).

► What are the applicable requirements related to initiating, conducting, and completing child abuse investigations involving group home staff as the alleged perpetrator?

The Department is required by statute to investigate alleged child abuse perpetrated by group home staff, and Department policies and procedures establish various requirements related to initiating, conducting, and completing child abuse investigations involving group home staff as the alleged perpetrator, including:³¹

● Initiating child abuse investigations involving group home staff

Department policies and procedures require hotline staff to determine if communications regarding suspected child abuse meet the statutory definition of a report that the Department is required to investigate, and if so, to assign a priority level to the report. Reports involving group home staff as the alleged perpetrator that involve potential criminal activity are assigned to OCWI for investigation, and noncriminal reports involving group home staff as the alleged perpetrator are forwarded to one of the investigative units in the Department's licensing office. Department investigators are required to make reasonable efforts to contact the child victim in person at their known or probable location within specific time frames (see page 6 for the required contact time frames).

³¹ For more information on the Department's responsibilities related to initiating, conducting, and completing investigations of allegations of neglect perpetrated by group home staff, see page 3, and Chapter 2, pages 20 through 22.

- **Conducting child abuse investigations involving group home staff**

Department policies and procedures require investigators to gather background information on the report, including the alleged perpetrator; interview alleged child victim(s), all other children living in the group home, alleged perpetrators, and other group home staff in the home; and gather and review any relevant information that may help substantiate or refute the allegation(s).

- **Completing child abuse investigations involving group home staff**

Department policies and procedures require all investigators to determine and document investigation findings in the Department's case-management system, make efforts to close the investigation, and notify the alleged perpetrator of the investigation finding once the investigation is closed.

See Chapter 1, pages 13 through 19, for 4 issues we identified with the Department's process for conducting investigations of group home staff alleged to have committed child abuse that do not fully address potential safety threats to children in group homes and risks to the investigative process. See also Chapter 2, pages 20 through 22, for information about the Department's lack of explicit statutory authority to place group home staff on the central registry for child neglect, which risks that some child neglect perpetrators can continue working with children unless otherwise prohibited by a criminal arrest, trial, or conviction.

- ▶ **What are the applicable time frames for initiating, conducting, and completing child abuse investigations involving group home staff?**

Statute and Department policy establish several time frames within which the Department is required to initiate, conduct, and complete child abuse investigations involving group home staff, as follows:

- Department policy establishes priority levels for reported allegations (see textbox on page 6 for more information on these time frame requirements and descriptions) and requires investigators to respond with in-person contact/attempted contact with the child victim within the following specific time frames:
 - ▶ **Priority 1 allegation**—Respond within 2 hours.
 - ▶ **Priority 2 allegation**—Respond within 48 hours.
 - ▶ **Priority 3 allegation**—Respond within 72 hours.
 - ▶ **Priority 4 allegation**—Respond within 7 days.
- Pursuant to A.R.S. §8-456, Department investigators must submit their written investigation findings into the Department's case-management system within 45 days of report receipt.
- Department policy requires investigators to make efforts to close the investigation within 60 days of report receipt.

Additionally, in our September 2025 special audit report that reviewed the Department's processes for investigating noncriminal reports of alleged child abuse and neglect, we found the Department did not timely complete and/or properly document some key investigative activities for noncriminal reports it received in fiscal year 2024 (see Arizona Auditor General report 25-109 *Arizona Department of Child Safety—Investigations of Noncriminal Child Abuse and Neglect Reports*). Specifically, although we found the Department made or attempted initial contact with alleged child victims within time frames required by its policies for 97% of all fiscal year 2024 noncriminal reports, it did not always complete, timely complete, and/or properly document some key activities for noncriminal child abuse and neglect investigations, including interviewing alleged child victims and entering investigation findings into its case-management system. Our September 2025 special audit report made several recommendations to the Department related to timely completing and documenting key noncriminal report investigation activities.

Our review of the Department's investigations of noncriminal reports alleging child abuse perpetrated by group home staff during this audit identified similar timeliness and documentation issues. For example, the Department took more than 60 days to close 36 of the 62 noncriminal reports involving group home staff it received between September 14, 2024 and December 1, 2025.³² We will include reports related to abuse in group homes as part of our followup to our September 2025 special audit that we initiated in April 2026 to assess the Department's progress in addressing timeliness and documentation issues.

³² As seen in Table 1, page 9, 62 of 93 (approximately 67%) reports involving group home staff as the alleged perpetrator the Department received between September 14, 2024 and December 1, 2025, were noncriminal.

Although our review did not identify systemic child safety or investigative process failures, Department's reported process for determining if it should remove group home staff under investigation for alleged abuse from having access to children does not fully address potential safety threats to children in group homes and risks to the investigative process

Department reported that it determines whether or not to remove group home staff under investigation for abuse from having access to children after assessing child safety

The Department reported that its standard process for handling investigations involving group home staff as alleged perpetrators of child abuse in group homes is to determine if and when to remove alleged perpetrators' access to children after assessing child safety.^{1,2} If the Department determines an alleged perpetrator's access to children should be removed, the Department reported that it then notifies the group home to do so, and according to Department policy, the Department's licensing office may follow up with the group home to ensure alleged perpetrators no longer have access to children. However, although we did not identify systemic child safety or investigative process failures, our review of a sample of 26 of 93 child abuse reports involving group home staff as alleged perpetrators identified that the Department's process does not fully address concerns regarding potential safety threats to children and risks to hindering the investigative process when group home staff continue to have access to children in the group home while under investigation, as exemplified in the 4 issues discussed below (see textbox, page 14, for more information about these concerns).^{3,4}

¹ The Department has not established a specific time frame in its policies and procedures for when investigators should determine if a group home staff's access to children should be removed. According to Department policy, investigators have between 2 hours to 7 days, depending on the report's priority level, to attempt to make contact with the alleged child victim. Department policy does not establish time frames for subsequent contact attempts if the investigator is unable to make contact with the alleged child victim on their initial attempt.

² As discussed in the Introduction, pages 5 through 6, according to Department policy, prior to the investigator making/attempting to make contact with the alleged child victim, the Department determines the priority level and response time for the report and completes other investigatory steps such as reviewing the allegation(s) and obtaining and reviewing various documentation such as background checks, prior history between the Department and the alleged perpetrator, and the alleged child victim's medical and school records.

³ The Department received these 93 reports against group home staff between September 14, 2024 and December 1, 2025.

⁴ The 26 reports in our sample included all 6 reports with a proposed substantiated finding, all 5 reports that were still open as of December 1, 2025, a random sample of 14 of 82 reports with unsubstantiated findings, and 1 judgmentally selected report from the remaining 68 unsubstantiated reports because it included an allegation of neglect with group home staff as the alleged perpetrator (see Chapter 2, pages 20 through 22, for more information about allegations of neglect involving group home staff).

Child welfare expert suggests that allowing group home staff under investigation for alleged abuse to have access to children in group homes could pose a safety threat to children and hinder the investigative process

According to the Child Welfare League of America (CWLA), group homes serve some of the most vulnerable young people in the United States, including children removed from their homes due to abuse or neglect. Additionally, CWLA reported that children in congregate-care settings, such as group homes, are more vulnerable and susceptible to abuse, and preventing and responding to maltreatment in group homes helps protect children from additional or continued abuse.¹ Further, according to CWLA, allowing a congregate-care staff member, such as a group home staff member, who is alleged to have abused a child within the congregate-care setting to have access to children in the group home while under investigation could pose a safety threat to children and could hinder the investigative process by allowing risks to the investigative process to go unaddressed.² Because child welfare agencies such as the Department are generally legally responsible for children in group homes, CWLA indicates that child welfare agencies have a higher responsibility and accountability when assessing and ensuring the safety of children with group home staff from that of parents.

¹ As discussed in Appendix B, page b-1, we contracted with CWLA, a coalition of public and private agencies whose mission is to advance equity through policies and practices that ensure the well-being of children, youth, families, and communities, to obtain expert consulting services related to child welfare practices.

² According to CWLA, the investigative process can be hindered if the alleged perpetrator has access to tamper with physical evidence, coach children on what to say to investigators, or collude with other group home staff on how to respond to investigators.

Source: Auditor General staff review of CWLA-provided information.

Issue 1: Department did not follow up with 2 nonresponsive group homes for reports we reviewed to ensure they removed alleged perpetrators' access to children as it had directed, and 1 alleged perpetrator was later alleged to have abused another child in a second group home while under Department investigation

Our review found that the Department notified group homes to remove alleged perpetrators' access to children in 7 of 26 reports we reviewed; however, in 2 of those 7 reports, the Department received no written response from the group home confirming that the alleged perpetrators no longer had access to children, and the Department was unable to provide any evidence that it followed up with these group homes regarding the lack of written response.^{5,6}

⁵ The Department's template email notification to group homes to remove alleged perpetrators' access to children requires the group home to remove the alleged perpetrator's access to children immediately upon receiving the notification and then provide a response that details the actions taken to ensure the alleged perpetrator does not have continued access to children within 2 calendar days of receiving the email. The template email indicates that the child welfare agency should provide a signed employment verification form confirming the alleged perpetrator's employment status. The Department received a response and the verification for the remaining 5 reports.

⁶ For 1 of these 2 reports, the Department was notified by law enforcement 6 days after the Department sent the notification that the alleged perpetrator had been arrested. For the other report, according to Department case-management system documentation, a group home representative reported to the Department that the alleged perpetrator would be removed from the group home. However, contrary to requirements outlined in the Department's notification email, the group home did not confirm in writing that the alleged perpetrator had been removed from access to children or provide a signed employment verification form detailing the actions the group home took to ensure the alleged perpetrator did not have continued access to children.

Further, 1 of the alleged perpetrators involved in 1 of the reports was the alleged perpetrator in another abuse report at another group home run by the same child welfare agency approximately 5 months after the Department sent the initial notice to remove the individual. Both reports involving this alleged perpetrator were priority 3 reports that alleged the individual physically abused a child, including throwing a child to the ground while trying to restrain them, and the Department proposed to substantiate 1 of 3 allegations from these reports and unsubstantiated the remaining 2 allegations.^{7,8} According to Department case-management system documentation, the group home reported contradictory and false information regarding this alleged perpetrator's location and employment status. By not following up with this group home for written confirmation that the alleged perpetrator did not have access to children, the Department lacked assurance on what actions the group home took regarding this alleged perpetrator, who the Department believed should not have access to children, to confirm the individual was not working in a group home setting.

The Department's lack of written procedures and/or guidance for handling nonresponsive group homes may have contributed to this issue (for more information about additional issues we identified with the Department's policies, procedures, and/or guidance, see Issue 3, pages 17 through 18). Specifically, Department policy states that investigators should notify the Department's licensing office when a group home has been notified to remove an alleged perpetrator's access to children and indicates that the licensing office may follow up with group homes to ensure alleged perpetrators no longer have access to children. However, the Department does not have written procedures or guidance regarding if, how, and when the licensing office should follow up with group homes, such as methods of contact, timelines, or steps to take if a group home fails to confirm in writing that the alleged perpetrator no longer has access to children.

Issue 2: Department's practice of interviewing the alleged child victim before determining whether to remove alleged perpetrators' access to children in group homes resulted in it not fully resolving potential safety threats to children and risks to the investigative process for 1.5 hours up to approximately 5 days for reports we reviewed

Our review also identified that the Department's practice of assessing child safety before determining whether to remove the alleged perpetrator's access to children in group homes allowed the safety threats to children and risks to the investigation process to not be fully resolved for 1.5 hours up to approximately 5 calendar days. According to the Department, its assessment of child safety in child abuse investigations involving group home staff as the alleged perpetrators generally occurs during the investigator's initial contact with the alleged child victim when the investigator does their assessment of whether the child is in present danger.^{9,10}

⁷ For the other report we reviewed, the group home voluntarily terminated the employee.

⁸ At the time of the second report the Department received about this group home staff member, the alleged perpetrator was working in a different group home than the group home at the time of the original report. According to the Department, the contract and license with this group home provider was later terminated because the provider was in default of its contractual obligations, including allowing staff to work in a group home while under investigations without the Department's consent.

⁹ As discussed in the Introduction, pages 5 through 6, in accordance with Department policy, the Department's initial contact or attempted contact with the child victim can be between 2 hours to 7 days after the Department receives the report, depending on the report's priority level.

¹⁰ According to Department policy, present danger is the immediate, significant, and clearly observable conditions that obviously endanger the child in that moment or threaten to endanger the child at any moment, requiring immediate intervention (see Arizona Auditor General report 25-109 *Arizona Department of Child Safety—Investigations of Noncriminal Child Abuse and Neglect Reports*, page 6, for more information about present danger).

However, we found that for the 14 of 21 reports we reviewed in which the alleged perpetrator at the group home was known and the Department followed this reported process, the Department took 32 hours on average, ranging between 1 hour and 23 minutes and approximately 5 days, to interview the alleged victim (see Appendix A, pages a-1 through a-4, for information about the time it took investigators to make contact with the child for each of these 14 reports).^{11,12} These 14 reports included allegations such as group home staff inappropriately touching children, injuring children, providing illegal substances to children, and putting children into dangerous situations.¹³

According to the Department, it does not remove all alleged perpetrators prior to determining child safety because it follows the same process used in the Department's investigations of parents and caregivers, including gathering information, reviewing the child and alleged perpetrator's history with the Department, interviewing the child, and assessing whether the child is in present danger, before determining whether the removal of the group home staff's access to children is necessary. However, the Department reported that the "SAFE AZ" practice model was designed for use in assessing parents, and our review of the Department's processes for investigating parents as compared to group home staff identified various SAFE AZ assessments and plans that the Department completes in investigations of parents that are not included in its investigations of group home staff (see textbox for a description of SAFE AZ).^{14,15}

For example, the Department completes an assessment in investigations of parents as alleged perpetrators that reviews the adult's functioning and practices for parenting, behavior management, and discipline, but the Department does not have a similar standardized assessment for determining whether an alleged perpetrator who is a group home staff member poses a safety threat to the alleged victim or other children in the

Key term

SAFE AZ: The Department's practice model for assessing family and child safety, making child safety determinations, and determining what interventions are needed to ensure child safety.

Source: Arizona Auditor General staff review of Action for Child Protection's SAFE model.

¹¹ Our review found that, for all 14 reports, the Department determined the alleged child victim(s) was not in present danger.

¹² For the remaining 12 of 26 reports, in 5 reports, the Department reported it was unable to identify an alleged perpetrator and therefore could not notify the group home of which staff should have access removed; in 4 reports, the alleged perpetrators had already been fired or placed on administrative leave by the group home or arrested by law enforcement when the 4 reports were made; and in 3 reports, the Department notified the group home to remove the alleged perpetrator's access to children prior to making initial contact with the alleged child victim.

¹³ See Appendix A, Table 3, pages a-2 through a-4, for a summary of the allegation(s) for each of the 14 reports. To maintain the confidentiality of the Department's investigation, the allegation summaries in Table 3 do not include specific details of each allegation or information the Department obtained during the investigation. As a result, although some of the report allegations have similar descriptions, each report's specific details and circumstances are unique, including what evidence the Department obtained to support or refute the occurrence of the alleged incident.

¹⁴ The Department's SAFE AZ practice model is based on the Safety Assessment and Family Evaluation (SAFE) practice model developed by Action for Child Protection in 1986. According to Action for Child Protection, its SAFE practice model is a conceptual framework that provides rationale, direction, and consistency for involvement with families by informing intervention outcomes, goals for service delivery, criteria for decision making, and practice approaches. Further, Action for Child Protection reports that a key tenet of the model is that it emphasizes the importance of working with the entire family system to meet the needs of family members, and as such, the practice model purposefully includes family members in key decision making for child safety planning. According to the Department, the SAFE AZ practice model is for assessing safety. Additionally, the Department reported that, although the SAFE AZ model is not for determining whether to substantiate or refute the allegation(s), it informs that decision.

¹⁵ See Arizona Auditor General report 25-109 *Arizona Department of Child Safety—Investigations of Noncriminal Child Abuse and Neglect Reports* for more information about the Department's processes for investigating parents and caregivers for reports of child abuse and neglect.

home.^{16,17,18} Further, the Department's reported process lacks mechanisms to mitigate the risks resulting from alleged perpetrator's access until the investigator can make this determination, such as calling the group home to determine if the alleged perpetrator is scheduled to work during the Department's initial child contact response time frame, requesting that the group home either remove the alleged perpetrator from working with children or provide additional supervision of the staff member until the Department can determine they do not pose a threat to children, and/or adjusting the initial child contact response time if it determines the staff member will have unsupervised access to the alleged victim during the required initial response time frame.¹⁹ Finally, although the Department contracted with a nonprofit organization that provides expertise for child welfare systems and programs, Action for Child Protection, to help develop its SAFE AZ model, according to the Department, its process for investigating group home staff was not similarly developed with help from outside experts.

Issue 3: Department lacks written policies, procedures, or guidance outlining its process for making and documenting decisions to remove alleged perpetrators' access to children in group homes, which may lead to inconsistent and inappropriate decisions

The Department lacks written policies, procedures, and/or guidance for staff outlining its reported process for making decisions to remove alleged perpetrators' access to children in group homes or written requirements for how those decisions should be documented, such as:

- ▶ If and when to require a child welfare agency to remove the group home staff member's access to children if they are under investigation for child abuse, including what factors should be considered in making this determination.
- ▶ What steps are necessary to determine that the group home staff member does or does not pose a safety threat to the alleged victim and/or other children in a group home.
- ▶ What information would or would not be sufficient for determining that the group home staff member does not pose a safety threat to children.
- ▶ How to document that a group home staff member was found to be or not to be a safety threat to children.

¹⁶ As discussed in our September 2025 special audit of the Department's investigations of reports of noncriminal child abuse and neglect, when investigating reports involving alleged abuse or neglect perpetrated by parents, investigators must complete an assessment to determine whether a child is safe or unsafe using 16 specific indicators of safety threats and identify the dynamics within the home, including child and adult functioning, parenting, behavior management, and discipline (see Arizona Auditor General report 25-109 *Arizona Department of Child Safety—Investigations of Noncriminal Child Abuse and Neglect Reports*, pages 7 through 8, for more information).

¹⁷ As discussed in the Introduction, page 3, the Department previously investigated allegations of abuse involving group home staff before June 30, 2023. Our review of the Department's policies and procedures from prior to June 30, 2023, did not identify a requirement for Department staff to document an assessment of the adult when the alleged perpetrator was a group home staff member.

¹⁸ According to the Department, it does not have a similar assessment for group home staff because the Department is not making a decision to remove a child from a parent and is instead determining whether there is enough information to substantiate an allegation. However, as discussed in Issue 3, pages 17 through 18, although the Department has a reported process for making decisions to remove an alleged perpetrator's access to children in group homes, it lacks written policies, procedures, and/or guidance outlining this decision-making process, including for how those decisions should be documented in its case-management system.

¹⁹ As discussed in the Introduction, pages 5 through 6, the Department is required to identify the priority level of all reports of alleged child abuse, and Department policy establishes the priority level and initial response times. According to the Department, initial response time frames are designed to correspond to the severity of the allegation and to ensure child safety. The Department also reported that modifying the response time is not realistic and would divert critical resources from situations that require immediate intervention. However, as previously discussed, the Department received 93 child abuse reports involving group home staff between September 14, 2024 and December 1, 2025, representing less than 0.002% of the 54,578 reports of child abuse and neglect it received in that time frame.

Without written policies, procedures, and/or guidance outlining the process and timelines for making and documenting decisions to remove alleged perpetrators' access to children in group homes, the Department risks that its investigators are making inconsistent, inappropriate, and/or untimely decisions regarding whether or not to remove alleged perpetrators' access to children. For example, we did not identify documentation in the Department's case-management system detailing the investigators' determinations or what information was used to make their determinations regarding the alleged perpetrators' continued access to children in the 14 reports previously discussed in which the Department made its determination regarding the alleged perpetrator's access after assessing the alleged child victim's safety. Without a documented explanation, it is not clear whether the Department made consistent, appropriate, and/or timely decisions regarding alleged perpetrators' access to children in the reports we reviewed. For example, the Department reported that it bases its decisions to remove alleged perpetrators' access to children on its present danger assessment of the child victim; however, the Department determined that none of the alleged child victims were in present danger in the 4 reports we reviewed in which it notified a group home to remove the alleged perpetrators' access to children after making initial contact with the alleged child victim.

As of May 2026, the Department reported that it recognized the need to update its policies and procedures, and that it could better clarify its reported process in its policies. Further, according to the Department, it is interested in reaching out to external child welfare experts and reviewing other state or jurisdiction practices for investigations of group home staff as the alleged perpetrator of child abuse.

Issue 4: Department contracts do not include written requirements outlining Department expectations for child welfare agencies regarding group home staff's access to children while under investigation, increasing the risk that group homes will act inconsistently and/or inappropriately

Additionally, our review of the Department's contracts with child welfare agencies found that they do not include specific written requirements outlining the Department's expectations regarding group home staff's access to children while under investigation. For example, the Department's contracts with child welfare agencies state that group home staff under investigation "shall have no direct care or indirect care responsibilities and shall not have contact or access to the child making the claim," which is inconsistent with the Department's reported process of only notifying the group home if the Department determines an alleged perpetrator's access to children should be removed. Without consistent written requirements outlining its expectations for group homes, the Department risks that group homes will act inconsistently and/or inappropriately, such as by not removing an alleged perpetrator's access to children when the Department notifies it to do so or not appropriately responding to the Department's notification to remove an alleged perpetrator.

As of May 2026, the Department reported that it recognized the need to update its contract language and could better clarify its expectations for child welfare agencies.

Recommendations to the Department

1. Develop and implement written policies, procedures, and/or guidance outlining when and how Department staff should follow up with group homes to help ensure that they have removed alleged perpetrator's access to children when the Department has notified them to do so, including when group homes do not respond to Department notifications. The policies, procedures, and/or guidance for conducting follow ups should outline the staff responsible for conducting follow ups, methods of contact, timelines, and steps to take if a group home fails to confirm alleged perpetrators no longer have access to children.
2. Develop and/or update and implement written policies, procedures, and/or guidance for making and documenting decisions to remove alleged perpetrators' access to children when they are a group home staff member under investigation for child abuse that address potential safety threats to children and risks of hindering the investigation process, including outlining required time frames, criteria, and detailed steps for assessing and determining if a group home staff member under investigation poses a safety threat to the alleged child victim and other children in group homes; requirements for documenting the assessment and determination that a group home staff member poses a safety threat to the alleged child victim and/or other children in group homes, including the information used to make the determination; and time frames and requirements for requiring the group home to remove the staff member's access to children if they are determined to pose a safety threat to the alleged child victim and/or other children in group homes.
3. Inform child welfare agencies of the Department's expectations regarding group home staff's access to children while under investigation, such as by updating its contract language with child welfare agencies to direct them to its updated policies, procedures, or written guidance regarding group home staff's access to children.

Department response: As outlined in its [response](#), the Department agrees with the finding and will implement the recommendations.

Department lacks explicit statutory authority to place group home staff on the central registry for child neglect and instead reviews neglect allegations as potential licensing violations, risking that child neglect perpetrators can continue working with children unless otherwise prohibited by a criminal arrest, trial, or conviction

According to statute and rule, if the Department substantiates an allegation of child abuse or neglect, it can place the perpetrator on the Department's central registry of child abuse and neglect (central registry), which is intended to disqualify persons found to have committed an act of child abuse or neglect from working in settings that provide direct services to children and vulnerable adults (see textbox for more information on the central registry).^{1,2} However, as of May 2026, although the statutory definition of child abuse explicitly includes acts committed by group home staff, the statutory definition of child neglect does not.³ Because the statutory definition of neglect does not explicitly include acts committed by group home staff, the Department reported it reviews allegations of neglect involving group home staff as potential licensing violations that cannot result in an alleged perpetrator being placed on the central registry rather than investigating them as reports of neglect, which if substantiated could result in placing the perpetrator on the central registry.

For example, if the Department substantiated a report of child neglect committed by the child's parent or other legal guardian providing a child

Central registry can be used to determine individuals' employment qualifications

The Department is legally required to maintain a central registry of child abuse and neglect that includes information on substantiated reports of child abuse or neglect, including the identity of the perpetrator of the child abuse or neglect. According to A.R.S. §8-804, the Department is required to conduct central registry background checks, and that information can be used as a factor to determine the qualifications of a person to work with children or vulnerable adults in certain settings. For example, central registry information can be used to determine individuals' qualifications to work as group home or child welfare agency staff or to provide direct services to children or vulnerable adults as State employees or contractors or licensed behavioral health staff.

Source: Auditor General staff review of Arizona Administrative Code (AAC) R21-1-501 and A.R.S. §8-804.

¹ AAC R21-1-508.

² A.R.S. §8-804.

³ As discussed in the Introduction, page 3, the statutory definition of abuse was revised effective September 2024 to include actions by group home staff, requiring the Department to investigate reports of abuse that include allegations perpetrated by group home staff. However, the statutory definition of neglect was not modified to include actions by group home staff, instead applying only to parents, guardians, and custodians.

with substances that may cause harm, such as controlled legal or illegal drugs, the Department could place the perpetrator on its central registry for 15 years.⁴ However, if the same allegation of neglect were made against a group home staff member, according to the Department, it can only determine if the alleged action constitutes a licensing violation and take corrective actions it deems necessary to ensure a group home remedies the issue(s), such as by requiring additional training for group home staff, increased monitoring of the group home, or restricting staff from a role that would involve direct contact with children.^{5,6,7} Although these licensing reviews may help to ensure the safety of children in the group home where the incident occurred, the licensing corrective actions do not include the possibility of placing group home staff who have been determined to have neglected children on the central registry to potentially prohibit them from working with children in the future in other settings, including at other group homes.⁸

Additionally, although the Department has established rules that could prohibit group home staff from continuing to work with children in a group home if neglect allegations result in a criminal arrest, trial, or conviction, these rules do not apply to noncriminal neglect. Specifically, according to the Department's rules, an individual must have a valid Arizona Level One fingerprint clearance card to be employed by a child welfare agency.^{9,10} According to the Department, its licensing system notifies the Department if a group home staff member's fingerprint clearance card becomes invalid because of an arrest for a precluding offense, and the Department may take licensing action if a group home does not promptly remove a staff member whose fingerprint clearance card becomes invalidated.¹¹ However, this process is contingent on law enforcement action, and as discussed in the Introduction, page 12, 62 of 93 group home reports the Department received between September 14, 2024 and December 1, 2025, were noncriminal reports. As a result, the Department's lack of explicit statutory authority to place group home staff on the central registry for neglect leaves open the possibility that group home staff who have committed noncriminal neglect can work with and potentially further neglect and/or harm children and vulnerable adults.

Further, although the Department's reported practice is not to investigate allegations of neglect perpetrated by group home staff other than through a licensing review, we found that 3 of 93 reports the Department investigated between September 14, 2024 and December 1, 2025, with

⁴ An individual could be placed on the central registry for 15 years for exposing a child to schedule 1 or schedule 2 nonprescribed drugs such as marijuana, fentanyl, and heroin.

⁵ Per A.R.S. §8-471(E), if the appropriate law enforcement agency has not already been notified, the Department is required to immediately notify the agency upon receipt for any report or information involving criminal conduct allegations.

⁶ According to Arizona Administrative Code, licensing concerns for group homes include various infractions, such as improper supervision, using or threatening to use physical punishment, and inadequate sleeping accommodations.

⁷ Our September 2023 performance audit of the Department found issues related to investigating, taking enforcement action against, and monitoring licensed out-of-home care providers could result in risky or unhealthy environments for children in out-of-home care (see Arizona Auditor General report 23-113 *Arizona Department of Child Safety—Licensed Foster Care Provider Oversight* for more information).

⁸ Pursuant to statute, the Department is required to place individuals it determines neglected or abused children on the central registry for up to 25 years, with time frames varying based on the type of the action.

⁹ AAC R21-7-104.

¹⁰ A fingerprint clearance card issued by the Arizona Department of Public Safety indicates that the cardholder is not awaiting trial for or has not been convicted of committing certain precluding criminal offenses, including felony child neglect. A Level One fingerprint card can be more difficult to obtain because it requires the applicant to not have been arrested or convicted of more precluding offenses than a standard fingerprint clearance card.

¹¹ The Department reported that although its licensing system automatically checks the status of all group home staff members' Arizona Level One fingerprint clearance cards and provides the Department with a report every weekday, the information from the system is only as accurate as the information reported by arresting jurisdictions to the Arizona Department of Public Safety and the timeliness of the Arizona Department of Public Safety's updates to an individual's fingerprint clearance card status.

group home staff as the alleged perpetrators included allegations of neglect.¹² For 2 of the 3 reports, Department investigators found sufficient evidence to propose the substantiation of the neglect allegations, including an instance where group home staff gave illicit drugs to a child and an instance where group home staff used an improper hold to restrain a child, which may have allowed the Department to place them on the central registry if they were a parent, guardian, or custodian as defined in statute.^{13,14} After we brought these investigations to the Department's attention during the audit, the Department removed the allegations from its case-management system, and the Department reported it did so because it is not legally allowed to enter findings in its case-management system for allegations of neglect on a group home staff member.^{15,16} According to the Department, investigators involved in these reports were unaware that they could not investigate neglect allegations involving group home staff, and it intends to educate its staff on responsibilities related to allegations of neglect perpetrated by group home staff.

Recommendations to the Department

4. Determine if statutory changes are needed to clarify the Department's authority related to investigating/substantiating reports of allegations of neglect perpetrated by group home staff.
5. If it determines statutory changes are needed, work with the Legislature to seek statutory changes related to investigating/substantiating reports of allegations of neglect perpetrated by group home staff.
6. If statutory changes are made, revise and implement the Department's policies and procedures to align with the Department's authority related to allegations of neglect perpetrated by group home staff.
7. Ensure Department staff are aware of Department processes for handling allegations of neglect perpetrated by group home staff, including any changes to its processes and updating its training.

Department response: As outlined in its [response](#), the Department agrees with the finding and will implement the recommendations.

¹² All 3 reports also included allegations of child abuse. For 2 of the 3 reports, the Department reported the allegations of neglect were added during their investigation of abuse allegations. For the remaining report, the Department reported that the neglect and abuse allegations were errantly recorded simultaneously upon receipt of the report because, although it is the Department's practice to record certain acts as both abuse and neglect allegations against an individual in certain circumstances, it is not supposed to do so for group home staff.

¹³ In accordance with rule, if a Department investigator proposes to substantiate an allegation, and a hearing is timely requested by the alleged perpetrator, the Department's Protective Services Review Team (PSRT) reviews the allegation and investigation information as one of the steps in the process to ultimately determine whether PSRT must place the perpetrator on the central registry. PSRT had not yet reviewed the 2 reports we reviewed for which Department investigators found sufficient evidence to propose the substantiation of the neglect allegations.

¹⁴ In 1 of the 2 reports that the Department investigators found sufficient evidence to propose the substantiation of neglect allegations, law enforcement arrested and charged the individual with a criminal offense.

¹⁵ The Department did not find evidence to propose the substantiation of the remaining report.

¹⁶ All 3 reports that included neglect allegations that the Department investigated also went through a licensing review. According to Department documentation, the Department took no licensing corrective actions in 2 of the 3 neglect allegations we reviewed because it determined there was not enough evidence to validate or refute the allegations, and it confirmed the corrective action the group home took in the remaining allegation, including firing the alleged perpetrator, was sufficient. See Arizona Auditor General report 23-113 *Arizona Department of Child Safety—Licensed Foster Care Provider Oversight* for more information on the Department's licensing corrective actions.

The Arizona Auditor General makes 7 recommendations to the Department

Click on a finding, recommendation, or its page number to the right to go directly to that finding or recommendation in the report.

Recommendations to the Department

CHAPTER 1	13
1. Develop and implement written policies, procedures, and/or guidance outlining when and how Department staff should follow up with group homes to help ensure that they have removed alleged perpetrator’s access to children when the Department has notified them to do so, including when group homes do not respond to Department notifications. The policies, procedures, and/or guidance for conducting follow ups should outline the staff responsible for conducting follow ups, methods of contact, timelines, and steps to take if a group home fails to confirm alleged perpetrators no longer have access to children.	19
2. Develop and/or update and implement written policies, procedures, and/or guidance for making and documenting decisions to remove alleged perpetrators’ access to children when they are a group home staff member under investigation for child abuse that address potential safety threats to children and risks of hindering the investigation process, including outlining required time frames, criteria, and detailed steps for assessing and determining if a group home staff member under investigation poses a safety threat to the alleged child victim and other children in group homes; requirements for documenting the assessment and determination that a group home staff member poses a safety threat to the alleged child victim and/or other children in group homes, including the information used to make the determination; and time frames and requirements for requiring the group home to remove the staff member’s access to children if they are determined to pose a safety threat to the alleged child victim and/or other children in group homes.	19
3. Inform child welfare agencies of the Department’s expectations regarding group home staff’s access to children while under investigation, such as by updating its contract language with child welfare agencies to direct them to its updated policies, procedures, or written guidance regarding group home staff’s access to children.	19

CHAPTER 2

20

4. Determine if statutory changes are needed to clarify the Department's authority related to investigating/substantiating reports of allegations of neglect perpetrated by group home staff. 22
5. If it determines statutory changes are needed, work with the Legislature to seek statutory changes related to investigating/substantiating reports of allegations of neglect perpetrated by group home staff. 22
6. If statutory changes are made, revise and implement the Department's policies and procedures to align with the Department's authority related to allegations of neglect perpetrated by group home staff. 22
7. Ensure Department staff are aware of Department processes for handling allegations of neglect perpetrated by group home staff, including any changes to its processes and updating its training. 22

Summary information about Department time to contact alleged child victims for 14 of 26 sampled reports with group home staff as the alleged perpetrator

Table 3 on pages a-2 through a-4 presents the results of our review of Department time to contact alleged child victims for the 14 of 26 reports where the Department made a determination of whether to remove the alleged perpetrator's access to children after conducting interviews with alleged child victim(s) (see Chapter 1, pages 15 through 17, for more information about these 14 reports).^{1,2} Specifically, in conducting our review of those reports, we reviewed the allegations against the group home staff, the time it took investigators to make initial contact with alleged child victims from when the report was received, and the time between report receipt and notification to the group home to remove an alleged perpetrator's access to children, if applicable (see Chapter 1, pages 13 through 19, for more information about issues we identified with the Department's reported process for removing group home staff's access to children while under investigation).

¹ We reviewed a sample of 26 of 93 reports with group home staff as the alleged perpetrator the Department received between September 14, 2024 and December 1, 2025 (see Appendix B, pages b-1 through b-2, for more information about our sample).

² For the remaining 12 of 26 reports, in 5 reports, the Department reported it was unable to identify an alleged perpetrator and therefore could not notify the group home of which staff should have access removed; in 4 reports, the alleged perpetrators had already been fired or placed on administrative leave by the group home or arrested by law enforcement when the 4 reports were made; and in 3 reports, the Department notified the group home to remove the alleged perpetrator's access to children prior to making initial contact with the alleged child victim.

Table 3

Department investigators took between 1 hour and 23 minutes and approximately 5 days to assess child safety in 14 reports we reviewed

Sampled report	Allegation description ¹	Priority level ²	Time from report receipt to:		Finding	Closure status as of April 2026
			Investigator contact with alleged child victim	Notification to remove alleged perpetrator's access		
Reports where the Department notified the group homes to remove alleged perpetrator’s access to children ³						
1	Evidence or disclosure of sexual abuse	1	1 hour 31 minutes	2 hours 38 minutes	Unsubstantiated	Closed
2	Group home staff physically or verbally imposing or threatening and other bodily injuries	3	24 hours 22 minutes (approximately 1 day)	25 hours 28 minutes (approximately 1 day)	1 allegation unsubstantiated 1 allegation proposed substantiated	Closed
3	Group home staff allows/ provides substances that may cause/caused harm	3	26 hours 58 minutes (approximately 1 day)	48 hours 42 minutes (approximately 2 days)	Unsubstantiated	Closed
4 ⁴	Group home staff physically or verbally imposing or threatening, face or head injury, and injuries due to neglect or failure to supervise	2	42 hours 47 minutes (approximately 2 days)	45 hours 34 minutes (approximately 2 days)	Unsubstantiated	Closed

Table 3 continued

Sampled report	Allegation description ¹	Priority level ²	Time from report receipt to:		Finding	Closure status as of April 2026
			Investigator contact with alleged child victim	Notification to remove alleged perpetrator's access		
Reports where the Department determined it did not need to remove alleged perpetrator’s access to children ³						
5 ⁴	Group home staff allows/ provides substances that may cause/caused harm	3	1 hour 23 minutes	No notification sent	Unsubstantiated	Closed
6	Evidence or disclosure of sexual abuse	1	2 hours	No notification sent	Unsubstantiated	Closed
7	Group home staff failed to protect/placed child in dangerous situation	3	17 hours 41 minutes (approximately 1 day)	No notification sent	Unsubstantiated	Closed
8	Other bodily injuries	3	20 hours 26 minutes (approximately 1 day)	No notification sent	Unsubstantiated	Closed
9	Other bodily injuries	3	21 hours 18 minutes (approximately 1 day)	No notification sent	Unsubstantiated	Closed
10	Group home staff physically or verbally imposing or threatening	2	21 hours 57 minutes (approximately 1 day)	No notification sent	Unsubstantiated	Closed
11	Group home staff allows/ provides substances that may cause/caused harm	3	23 hours 5 minutes (approximately 1 day)	No notification sent	Unsubstantiated	Closed
12	Group home staff allows/provides substances that may cause/caused harm	3	42 hours 10 minutes (approximately 2 days)	No notification sent	Unsubstantiated	Closed

Table 3 continued

Sampled report	Allegation description ¹	Priority level ²	Time from report receipt to:		Finding	Closure status as of April 2026
			Investigator contact with alleged child victim	Notification to remove alleged perpetrator's access		
Reports where the Department determined it did not need to remove alleged perpetrator's access to children ³						
13	Group home staff physically or verbally imposing or threatening	2	91 hours 41 minutes (approximately 4 days) ⁵	No notification sent	Unsubstantiated	Closed
14	Group home staff physically or verbally imposing or threatening	3	116 hours 54 minutes (approximately 5 days) ⁵	No notification sent	Unsubstantiated	Closed

¹ This allegation description is a summary and does not include specific details of each allegation or information obtained by the Department during the investigation. These details were omitted to maintain the confidentiality of the Department's investigation. As a result, although some allegations appear similar, the specific details and circumstances of each report are unique, including what evidence the Department obtained supporting or refuting the occurrence of the alleged incident.

² As discussed in the Introduction, page 6, the Department's priority response time frames are 2 hours for priority 1, 48 hours for priority 2, 72 hours for priority 3, and 7 days for priority 4.

³ As discussed in Chapter 1, pages 15 through 18, we did not identify documentation in the Department's case-management system detailing the investigators' determinations or what information was used to make their determinations regarding the alleged perpetrator's continued access to children for any of these 14 reports. Without a documented explanation, it is not clear whether the Department made consistent, appropriate, and/or timely decisions regarding the alleged perpetrator's access to children in reports we reviewed.

⁴ This report also had a neglect allegation (see Chapter 2, pages 20 through 22, for more information about neglect allegations against group home staff).

⁵ Investigators made an attempt to contact the alleged child victim within the required response time, before being able to make contact and assess for safety.

Source: Auditor General staff review of Department case-management system information and Department-provided information for 14 of our 26 sampled reports of child abuse or neglect involving group home staff as the alleged perpetrator that the Department received from September 14, 2024 through December 1, 2025.

Scope and methodology

The Arizona Auditor General has conducted this special audit of the Department pursuant to a September 18, 2024, resolution of the Joint Legislative Audit Committee.

We used various methods to address the audit's objectives. These methods included reviewing State statutes; the Department's website; Department policies, procedures, and guidance for investigating child abuse and neglect reports; and interviewing Department staff.

In addition, we used the following specific methods to meet the audit objectives:

- ▶ To determine whether the Department investigated child abuse reports alleging child abuse perpetrated by group home staff it received between September 2024 and December 1, 2025, as required by statute, Department policy, and recommended practices, we reviewed:
 - The Department's case-management system and data as of January 2026 and Department-provided information for a sample of 26 of 93 reports involving group home staff that the Department received between September 14, 2024 and December 1, 2025.¹ Our sample of 26 of 93 reports consisted of:
 - ▷ All 6 reports with a proposed substantiated or substantiated finding.
 - ▷ All 5 reports that were still open as of December 1, 2025.
 - ▷ A random sample of 14 of 82 reports with unsubstantiated findings.
 - ▷ One report we judgmentally selected because it included an allegation of neglect.²
 - Child Welfare League of America (CWLA)-provided information on child welfare investigation research and recommended practices.³
 - The Department's template contract language for licensed group homes.
 - Department contracts with 3 judgmentally selected group homes related to our sample of 26 of 93 reports.⁴
 - Arizona Auditor General report 25-109 *Arizona Department of Child Safety—Investigations of Noncriminal Child Abuse and Neglect Reports*.

¹ We reviewed investigatory case notes in the Department's case-management system, including case notes about interviews and contact with the alleged child victims, alleged perpetrators, other individuals working or residing in the group home, the reporting source, and law enforcement. Additionally, as applicable, we also reviewed assessments of whether children were in immediate danger, allegations and findings, documented communications with group homes, and Department licensing documentation.

² We judgmentally selected the 1 report with an allegation of neglect from the 68 remaining unsubstantiated reports after we selected our random sample of 14 of 82 unsubstantiated reports.

³ We contracted with CWLA, a coalition of public and private agencies whose mission is to advance equity through policies and practices that ensure the well-being of children, youth, families, and communities, to obtain expert consulting services related to child welfare practices.

⁴ We judgmentally selected the Department's contracts with 3 group homes in which the group home staff member in our sampled reports became the alleged perpetrator in a new report while under investigation for alleged child abuse.

- ▶ To obtain information for Chapter 2, we reviewed:
 - The Department's case-management system and data and Department-provided information for all 3 reports the Department investigated between September 14, 2024 and December 1, 2025, that included an allegation of child neglect with group home staff as the alleged perpetrator (see page 13 for more information about our sample selection).⁵
 - Arizona Administrative Code.
 - Arizona Auditor General report 23-113 *Arizona Department of Child Safety—Licensed Foster Care Provider Oversight*.
 - Department policies and procedures for substantiating allegations of child abuse and neglect.
- ▶ To obtain information on the different types of child abuse reports involving group home staff that the Department investigates, including criminal and noncriminal reports, we reviewed Department policies and procedures for child abuse and neglect investigations and A.R.S. §§8-201 and 8-455.
- ▶ To obtain information for the Introduction, we reviewed Department-provided data regarding investigative staffing and vacancies and licensed group homes, session laws, the Department's March 2026 *Monthly Operational and Outcome Report*, and Department case-management system data for all 93 reports of child abuse reports alleging child abuse perpetrated by group home staff it received between September 14, 2024 and December 1, 2025.⁶

Our work on internal controls included, where applicable, reviewing the Department's policies and procedures and testing Department compliance with these policies and procedures. We reported our conclusions on applicable internal controls in Chapters 1 and 2.

We selected our audit sample(s) to provide sufficient evidence to support our findings, conclusions, and recommendations. Unless otherwise noted, the results of our testing using these samples were not intended to be projected to the entire population.

When relying on Department-provided data to support our findings and conclusions, we performed certain tests to ensure the data was sufficiently valid, reliable, and complete to meet the audit objectives. Unless otherwise noted, we determined the Department-provided data was sufficiently valid, reliable, and complete for audit purposes.

We express our appreciation to Director Ptak and Department staff for their cooperation and assistance throughout the audit.

⁵ As discussed in Chapter 2, page 20, we identified that 3 of 93 reports the Department received involving group home staff as alleged perpetrators between September 14, 2024 and December 1, 2025, included allegations of neglect that the Department investigated.

⁶ We analyzed data from the Department's case-management system that was both provided by the Department and that we extracted using queries developed with Department staff assistance.

DEPARTMENT RESPONSE

The subsequent pages were written by the Department to provide a response to each of the findings and to indicate its intention regarding implementation of the recommendations resulting from the audit conducted by the Arizona Auditor General.

September 1, 2026

Lindsey Perry, CPA, CFE
Auditor General
Arizona Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

RE: Special audit of the *Arizona Department of Child Safety – Investigations of Reports Involving Child Welfare Agency Staff*

Dear Ms. Perry:

The Arizona Department of Child Safety (Department) acknowledges the audit of its processes for investigating child abuse reports involving group home staff and has reviewed the report.

The Department appreciates the audit's conclusion that no systemic child safety or investigative process failures were identified.

The report affirms the Department's ongoing focus on timely, consistent, and accountable practice. It further recognizes the Department's willingness to clarify policies, procedures and contract expectations and to strengthen investigative processes, reflecting the Department's commitment to continuous improvement.

The Department values the Auditor General's review and remains committed to implementing improvements while building upon the strengths identified in the audit

Attached is the Department's formal response to the findings and recommendations, outlining steps to enhance policies, documentation practices and processes that support child safety and investigative integrity.

Sincerely,

Signed by:



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Kathryn Ptak
Director

Enclosure: DCS Recommendation Response

Chapter 1: Although our review did not identify systemic child safety or investigative process failures, Department's reported process for determining if it should remove group home staff under investigation for alleged abuse from having access to children does not fully address potential safety threats to children in group homes and risks to the investigative process.

Department response: The Auditor General's finding is agreed to.

Response explanation: The Department appreciates that the audit identified no systemic child safety or investigative process failures. The Department is committed to strengthening its process for determining if it should remove group home staff under investigation for alleged abuse.

Recommendation 1: Develop and implement written policies, procedures, and/or guidance outlining when and how Department staff should follow up with group homes to help ensure that they have removed alleged perpetrator's access to children when the Department has notified them to do so, including when group homes do not respond to Department notifications. The policies, procedures, and/or guidance for conducting follow ups should outline the staff responsible for conducting follow ups, methods of contact, timelines, and steps to take if a group home fails to confirm alleged perpetrators no longer have access to children.

Department response: The audit recommendation will be implemented.

Response explanation: The Department will establish clear policies, procedures and/or guidance for staff to identify when to follow up with group homes after notification to remove alleged perpetrators' access to children. The policies, procedures and/or guidance will include defining responsible parties, methods of contact, timelines and escalation steps for non-responsive group homes.

Recommendation 2: Develop and/or update and implement written policies, procedures, and/or guidance for making and documenting decisions to remove alleged perpetrators' access to children when they are a group home staff member under investigation for child abuse that address potential safety threats to children and risks of hindering the investigation process, including outlining required time frames, criteria, and detailed steps for assessing and determining if a group home staff member under investigation poses a safety threat to the alleged child victim and other children in group homes; requirements for documenting the assessment and determination that a group home staff member poses a safety threat to the alleged child victim and/or other children in group homes, including the information used to make the determination; and time frames and requirements for requiring the group home to remove the staff member's access to children if they are determined to pose a safety threat to the alleged child victim and/or other children in group homes.

Department response: The audit recommendation will be implemented.

Response explanation: The Department will develop and update written policies and procedures that clearly define how staff assess and document decisions to remove a group home staff member's access to children during an abuse investigation. These updates will outline required time frames, criteria for determining safety threats and the

specific steps staff must follow when evaluating and documenting whether a staff member poses a risk to an alleged victim or other children.

The Department will also establish clear requirements for documenting the assessment and determination, including the information relied upon and set time frames for directing group homes to remove staff access when a safety threat is identified.

Recommendation 3: Inform child welfare agencies of the Department's expectations regarding group home staff's access to children while under investigation, such as by updating its contract language with child welfare agencies to direct them to its updated policies, procedures, or written guidance regarding group home staff's access to children.

Department response: The audit recommendation will be implemented.

Response explanation: The Department will inform child welfare agencies of expectations regarding group home staff's access to children during investigations, including updating contract language to reference the revised policies and procedures rather than citing the specific expectations outlined in policies and procedures.

Chapter 2: Department lacks explicit statutory authority to place group home staff on the central registry for child neglect and instead reviews neglect allegations as potential licensing violations, risking that child neglect perpetrators can continue working with children unless otherwise prohibited by a criminal arrest, trial, or conviction.

Department response: The Auditor General's finding is agreed to.

Response explanation: The Department acknowledges limitations in placing group home staff on the Central Registry for child neglect and continues to review neglect allegations as potential licensing violations. However, criminal investigations may still occur under Arizona Revised Statutes Title 13.

Recommendation 4: Determine if statutory changes are needed to clarify the Department's authority related to investigating/substantiating reports of allegations of neglect perpetrated by group home staff.

Department response: The audit recommendation will be implemented.

Response explanation: The Department will review statutes and policies from other states related to group home staff investigations, review data as to volume of potential allegations and determine if any or all categories of neglect could apply to group home shift staff in order to enhance child safety.

The Department will then determine whether statutory changes would clarify the Department's authority related to investigating and substantiating reports of alleged neglect perpetrated by group home staff.

Recommendation 5: If it determines statutory changes are needed, work with the Legislature to seek statutory changes related to investigating/substantiating reports of allegations of neglect perpetrated by group home staff.

Department response: The audit recommendation will be implemented.

Response explanation: If it is determined that statutory changes are necessary to clarify the Department's authority to investigate and substantiate allegations of neglect perpetrated by group home staff, the Department will work with the Legislature to pursue those statutory changes and ensure the authority needed to properly address neglect concerns in group home settings.

Recommendation 6: If statutory changes are made, revise and implement the Department's policies and procedures to align with the Department's authority related to allegations of neglect perpetrated by group home staff.

Department response: The audit recommendation will be implemented.

Response explanation: If statutory changes are enacted, the Department will revise and implement its policies and procedures to align with updated authority regarding neglect allegations by group home staff.

Recommendation 7: Ensure Department staff are aware of Department processes for handling allegations of neglect perpetrated by group home staff, including any changes to its processes and updating its training.

Department response: The audit recommendation will be implemented.

Response explanation: If statutory changes are made, the Department will ensure staff are informed of processes for handling neglect allegations by group home staff, including updates to training and communication of any process changes. Education and guidance will be provided to staff to maintain awareness and compliance.