

# **SPECIAL REPORT**

## **Issues Related to the Shelby County Operations of the Department of Children's Services**

**November 2003**

**John G. Morgan  
Comptroller of the Treasury**



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**John G. Morgan**  
Comptroller

November 24, 2003

The Honorable John S. Wilder  
Speaker of the Senate  
The Honorable Jimmy Naifeh  
Speaker of the House of Representatives  
The Honorable John J. DeBerry, Jr., Vice-Chair  
House Children and Family Affairs Committee  
Members of the House Children and Family Affairs Committee  
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is this office's report on the investigation into issues related to the Shelby County operations of the Department of Children's Services, as requested by the House Committee on Children and Family Services.

Sincerely,

John G. Morgan  
Comptroller of the Treasury

JGM/js

# **ISSUES RELATED TO THE SHELBY COUNTY OPERATIONS OF THE DEPARTMENT OF CHILDREN'S SERVICES**

**November 2003**

## **Department of Children's Services**

This report, the result of a request from the House Children and Family Affairs Committee, is a follow-up investigation to the July 9, 2003, report by the Department of Children's Services (DCS) regarding the deaths of numerous children in Shelby County. Committee members were concerned about the possibility of a department cover-up relating to the facts or circumstances of these deaths, or of other related inappropriate actions by department staff.

We found that DCS performed a thorough and complete review of the deaths and their conclusions appear adequately founded. There is no evidence that came to their attention or to our attention that supports a cover-up relating to the deaths or any other related inappropriate actions by department staff. However, there are a number of other issues in the Shelby County operations that DCS management needs to address.

## **I. Project Background**

### **A. Memo From Representative Bowers**

On June 2, 2003, Representative Kathryn Bowers sent a memo to the Department of Children's Services (DCS) asking the department to investigate allegations surrounding the deaths of several children connected to the Shelby County office. Representative Bowers stated in the memo that there had been up to eight deaths based on "information that has been sent to me," and she requested that DCS "investigate the deaths of these children." The memo named three children, listed other case managers and supervisors who allegedly had deaths in their units, and named seven current and former DCS employees who "have knowledge" of these matters.

### **B. Department of Children's Services Report**

The department conducted an investigation and presented the results to the House Children and Family Affairs Committee in a report dated July 9, 2003. Department staff could substantiate the deaths of 5 of the 11 children alleged in the memo. The department concluded that there was no effort on the part of staff to cover up the deaths of the children.

However, they did find significant performance and practice problems that require administrative action. These will be described and discussed later in this report.

### **C. Request to Comptroller of the Treasury**

The day after Department of Children's Services report was released the committee held a previously scheduled hearing in Shelby County and discussed, among other things, the conclusions of the report. Because of statements made during that hearing, the committee chair at the time, former Representative Carol Chumney, requested that the Comptroller of the Treasury conduct "an independent investigation as to whether or not the child deaths in question were 'covered up.'" This request was also contained in an August 6, 2003, memo to the Comptroller of the Treasury which also directs that the findings be reported to the House Children and Family Affairs Committee.

At the August 21 hearing in Nashville, Representative Chumney provided additional guidance for the Comptroller's investigation. She requested that the auditors interview management and staff in the Shelby County office, look at the way DCS conducted its investigation, and look at the rate of child deaths in Shelby County compared to other areas of the state. She asked for the auditors to inquire about pressure on employees not to report deaths and to review what former DCS employees said in public hearings to see what else may need to be considered. Auditors were also directed to confer with Representatives Kathryn Bowers, Lois DeBerry, and John DeBerry. These items became part of the auditors' planned procedures.

## **II. Report of the Department of Children's Services Special Investigations Unit**

### **A. The Deaths of Five Children**

The Department of Children's Services report summarizes the results of the review into the circumstances of the deaths of the five children identified by Representative Bowers without giving case-specific information. Problems related to case management listed in the report include the following items:

- Investigations were not comprehensive.
- There was a failure to conduct interviews of all persons likely to have knowledge.
- There was a tendency to narrowly focus on one aspect of the case.
- There was a lack of coordination with medical professionals and the police.
- There was little evidence of supervisory support or legal consultation.
- There was a lack of follow-up with families.

The department determined steps to correct the situation, compiled in the "Shelby County Corrective Action Plan," issued with the above report. Steps to be implemented include the following:

- Additional staff will assist in reviewing all reports of injured children to monitor and model best practices and to ensure casework is complete, sound in technique, and sensitive to risks.
- Training will be provided to all Child Protective Services (CPS) case managers and supervisors on assessing risk of vulnerable children, collaborating with the medical community and law enforcement, and effective decision-making.
- The department will create a “learning lab” for newly hired employees to build their skills.
- The department will revise CPS job performance plans, job expectations, and the means for evaluating performance.
- The department will provide cell phones to CPS workers for emergency calls from the field, will develop internal work groups, and develop procedures for approval of overtime.
- The department will improve the working relationship with the Child Advocacy Center, the Child Protective Investigation Team (CPIT), and the medical community by revising protocols and functions.

## **B. Other Matters**

In conjunction with the review of individual child deaths, the special investigations unit (SIU) reviewed regional operations, including interviews with community stakeholders, regional managers, and direct service workers. They made the following conclusions:

- There has been a breakdown in communication and coordination between central office staff (Nashville) and the Shelby County region.
- Shelby County region leadership became alienated from significant community stakeholders such as the Shelby County Juvenile Court, the medical community, and other service providers.
- There have been frequent transfers of case managers and supervisors from team to team and from one program to another. This has resulted in inexperienced supervisors being responsible for program areas.
- There has been an increase in child protective services caseloads for case managers with the average number of new reports per case manager per month climbing from 10 to 16.

The department also determined steps to correct these problems. These steps, noted in the “Shelby County Corrective Action Plan,” include the following:

- The commissioner will join the state Child Death Review Team, appoint a new state director of CPS, participate in Shelby County implementation of this plan, and actively monitor regional performance through on-site reviews and written reports.
- Assistant commissioners and program directors in the central office will have regular contact with the regions to review performance and offer consultation, support, and training.

- Interim assignments of new administrative and program administrators will be followed by permanent appointments within 90 days. Community representatives will be invited to join the recruitment and selection process.
- The department will evaluate all supervisory staff and make reassignments to match staff knowledge and skills with assignments.
- The department will apply corrective and disciplinary measures as needed.
- The department will allow front-line supervisors to interview and contribute to decisions on hiring and assignment.

### **III. The Process of the Auditors**

#### **A. In General**

We first met with the commissioner and with top-level DCS management to determine which staff had been involved in the department's investigation and to obtain the names of others to contact for further assistance. We listened to the hearing tapes and read additional documentation provided by those who testified at the hearings. We contacted Representatives Carol Chumney, Kathryn Bowers, Lois DeBerry, and John DeBerry. We reviewed the case files of the five children named in the original memo. We reviewed DCS policies and obtained access to TNKIDS, the DCS database of case information, to view case files online. We interviewed SIU staff responsible for planning and conducting the department's investigation and read their relevant notes, reports, and e-mails.

We traveled to Shelby County and visited the CPS office on Third Street, the office of Child and Family Services in the State Office Building on North Main Street, the Memphis Child Advocacy Center on Poplar Avenue, and two other locations to conduct interviews. We interviewed approximately 40 people, including 23 current DCS staff in Shelby County, the executive director of the Memphis Child Advocacy Center (a private non-profit agency serving children who are victims of sexual abuse), the previous Shelby County regional administrator, and six former DCS employees. The employee group in Shelby County included the two interim regional administrators, five team coordinators, three team leaders, ten additional case managers, and three administrative staff who work directly with the case files. There were 11 staff who work exclusively with Child Protective Services and 4 who specialize in Child and Family Services. Seven of the staff we interviewed in Shelby County had also been interviewed as part of the department's investigation. Following the interviews, we received further information from some of the people by overnight delivery, e-mail, fax, and phone calls.

#### **B. Regarding the Five Deaths**

We reviewed case information in both paper files and on TNKIDS for the five children referred to in the memo from Representative Bowers. We interviewed people who had a connection to the cases. We interviewed and obtained written information from former employees who had been outspoken about issues in Shelby County.

### **C. Regarding the SIU Methodology**

We interviewed DCS staff in charge of the investigation and those who assisted with interviews, case reviews, and other activities. We obtained the investigation schedule, interview questions and notes, and e-mails of information sent to and between SIU members. We reviewed the draft of their file review of the five cases in question. We reviewed the summary report from the interviews held with staff in Shelby County that listed the areas of concern and the issues that later constituted the final report.

### **D. Regarding the Child Death Rate in Shelby County Compared to Other Areas**

We attempted to determine, by region, the rate of deaths of children while in state custody or while the subject of a state investigation, to compare the rate in Shelby County to rates in other areas of Tennessee. We obtained information from the SIU on their efforts to gather information in this area. We contacted staff of the Department of Health and the Department of Children's Services to obtain any data they have.

### **E. Regarding the Concerns of Employees**

As part of the interviews mentioned above, we asked questions of DCS employees in Shelby County related to allegations brought to our attention at the start of our investigation.

## **IV. Our Findings**

### **A. On the Five Deaths**

We found that the DCS investigation was conducted by the SIU, a group created as a result of the Brian A. settlement agreement. With assistance from other DCS staff, the SIU interviewed approximately 40 people in Nashville and in Shelby County. They talked with CPS staff, foster care staff, staff responsible for TNKIDS, DCS attorneys, and local guardians *ad litem*. SIU talked with representatives of community organizations such as the Shelby County Board of Education, the Court Appointed Special Advocate, juvenile court administration, the Exchange Club of Memphis, LeBonheur Children's Hospital, the Memphis Child Advocacy Center, and the Shelby County community services agency. They also interviewed members of the newly created DCS team decision-making unit. In addition, the SIU group obtained data from TNKIDS and reviewed information in over 200 paper case files. The SIU gathered personnel information related to disciplinary actions and reviewed data on TNKIDS and in paper case files. To ascertain procedures, staff of the SIU interviewed people from the DCS Licensing division and from the General Pediatrics Division of Vanderbilt University. The SIU interview questions were detailed and extensive.

We reviewed the documentation of the SIU review of the five cases. Following is an extract of the SIU summary.

### *Child 1*

This child died of dehydration and blunt trauma to the stomach. The uncle was arrested for the murder of the child.

The family had been known by DCS since August 4, 2000, when a sibling was seen at LeBonheur Children's Hospital. The aunt and uncle of the children had been awarded custody of the five siblings; however, documentation for a mandated home study could not be located. There were new allegations of abuse, but DCS released the children back into custody of the aunt and uncle. The family was then referred by DCS to receive services in the home, eventually achieving favorable results. One of the siblings was seen in the hospital for an injury requiring stitches, but no report to DCS was made. A later allegation involving sexual abuse was made against the uncle, but the report was unfounded. The case eventually was reassigned and a case manager was given specific tasks to complete, but the only follow-up was a phone call to the aunt. The child died a few months later.

SIU determined the investigations in the case were weak and not thorough enough to identify how some of the injuries had happened to the children. The specific concerns of the department include the following:

- Failure to conduct interviews of all the persons who were likely to have knowledge of the incidences of abuse. There is no record of DCS staff attempting to get information from any of the children in previous investigations.
- There was no evidence of a joint investigation conducted by the CPIT team and no joint classification or sharing of investigative information with the police prior to the child's death.
- There was no follow-up with medical professionals to verify the excuses and explanations for injuries. DCS assumed the explanations were accurate.
- There were no efforts to gather information through observation of possible locations where the abuse occurred, no home visits to reenact these incidents, and no interviewing specific to the chain of events that led up to the abuse.
- The files do not show how all the allegations were classified or that supervisors played a role in classification or safety decisions.
- After the incidents occurred and the children were sent back to the same home, there was little or no follow-up with the family, with other family members, or with other agencies that may have served the family. With the exception of the home family referrals, DCS made no referrals for services.

It appears the department did not grasp the seriousness of the allegations and did not engage in sufficient investigative activity to understand the cause of the injuries and the dynamic situation of the family.

### *Child 2*

This child arrived at LeBonheur Children's Hospital with seven broken ribs, head and neck injuries, and later died. The child's father was arrested for murder.

The child had a previous visit to LeBonheur with multiple marks on his body and elevated liver enzyme levels. The child was discharged after DCS felt the marks could have been caused by another sibling pinching the child. DCS was scheduled to follow up with the family and subsequently did. However, this was the last contact before the child's death. The department ruled there was no sense of urgency in investigating the bruises and elevated enzyme levels. The initial injuries to this child were mysterious but not life-threatening.

SIU viewed the CPS investigation as weak because staff did not interview the father throughout the process. In addition, more information should have been obtained to understand how the child received the bruises and elevated liver enzyme levels. In addition, there was no effort by DCS to understand the dynamics of the family.

### *Child 3*

The siblings were in the custody of their great-grandfather and his wife after a situation in their birth home caused a change of residence. The day of the injury the child was taken to LeBonheur Children's Hospital for a serious injury to her throat. DCS determined that the great-grandfather's wife was responsible for severe abuse of the child and substantial risk of physical injury for a sibling.

The department did have a history with the sibling group. The last contact with CPS was approximately six years before the death of the child. A troubling note about this case is the fact that three of the wife's children had been previously removed from her care at the same residence where this child and her sister were living at the time of this child's death. This means DCS custodial case managers should have observed these two young girls living in the same environment and should have stated concerns about their presence in the home. SIU concluded that the greatest concern is the lack of follow-up on this child and her sister once they were placed in the great-grandfather's home.

### *Child 4*

This child was born with Jejunal atresia, or "short gut syndrome," and required a high level of personal care and tube feeding. He was hospitalized many times during his life for infections and other complications of this illness. He was in state custody at the time of his death, and his death was attributed to his chronic health problems.

The child entered the state's custody because of the mother's unwillingness to care for the child. The child had to be hospitalized for medical problems that were intensified by the mother's lack of care and failure to feed the child.

SIU had concerns about how DCS staff managed this case. According to documentation by DCS and medical staff, the mother appeared to be unable or unwilling to accept responsibility for the care of the child. The mother's lack of attention was evidenced by her failure to visit the child when he was hospitalized and sporadic attendance at training to learn how to care for her child. However, the case notes show the case manager's determination in attempting an unsuccessful extended home visit with the mother. SIU concluded staff should have used better case management and been more sensitive to the family's situation. In addition, the case manager's insistence for the mother to assume a primary caretaker role was not in the child's best interest.

#### *Child 5*

This child was declared dead on arrival at LeBonheur Children's Hospital, and the medical examiner ruled the death a homicide. The child had initially been brought to LeBonheur with a skull fracture and broken wrist.

SIU felt the case manager failed to appreciate the importance of the history of the family and did not have access to information that may have cast doubts about the parent in the case. Therefore, the staff responsible for decision-making during the investigation minimized the risk issues present. There was no follow-up with medical professionals and a lack of concern for the risk issues for the child.

#### *Auditors' Conclusion*

We found the SIU was thorough in its investigation of these cases and that the July 9, 2003, report accurately depicts the problems found. However, the level of detail of the report to the House Children and Family Affairs Committee did not sufficiently describe the methodology used and the extent of support for the findings in the report. The information we gathered supports their conclusions. There is no evidence that came to their attention or to our attention that supports a cover-up related to these cases.

### **B. On the Child Death Rate in Shelby County Compared to Other Areas**

When a child dies in Tennessee, the situation is reviewed by one of the child death review teams, created by statute and managed by the Department of Health. When a child in DCS custody dies, a report and case information are sent to the Nashville office. We found, however, that neither the Department of Health nor the Department of Children's Services maintains information on death rates of children in state custody. Therefore, we were unable to either obtain the rate in Shelby County or compare it to other areas.

### **C. On Pressure on Employees**

Prior to our work, there were allegations in public hearings and privately to legislators that documents were destroyed, that case workers lied during the interviews with the DCS investigators, and that staff frequently added information to cases about things that did not happen. The DCS investigation did not support these allegations. Our limited review and available information did not find evidence to substantiate these charges, either.

Staff of the Shelby County office shared numerous complaints about the operation of the office, particularly under the former regional administrator. The most pervasive complaints seem to stem from what was viewed as an oppressive management style that used to exist throughout the office and is still not entirely removed. For example, according to staff, all case workers used to be required to be in the office on Wednesday to enter case information on the TNKIDS computer system, even though this often overloaded the system.

According to the former regional administrator, when she took her position, she noted a lack of contacts made by case managers and a lack of compliance with other department policies. This is supported by the November 2003 compliance report of the Brian A. monitor and by the November 2003 performance audit of the department. According to the regional administrator, to encourage accountability on the part of case managers and to try to comply with department policy, she instituted certain practices. To encourage attendance, case managers were required to sign in and out of the office in a central location. To try and catch up on entries in case files, Wednesday was designated as “office day,” a time to prepare documentation and enter activity into TNKIDS.

The former regional administrator said that when she was hired in May 2000, she was told that the CPS section would not fall under her responsibility. The CPS director at the time, who had been employed by the state for 28 years, would maintain responsibility for CPS and would report to the state CPS director in Nashville. According to the regional administrator, after about two years she was requested by CPS staff to meet and discuss problems in that section. Shortly after that, the regional administrator decided to become directly involved in CPS. She said that she read cases, offered advice to case managers, and administratively closed cases that had been open for up to four years. (By policy, case managers are required to close CPS cases within 60 days.) The CPS director tendered her resignation, effective August 2002. During this time and through 2003, there were numerous allegations against the regional administrator in letters to the commissioner, legislators, and the Governor. Former DCS employees contacted legislators and testified at hearings in Memphis and Nashville, which led to this investigation by the Comptroller of the Treasury.

The regional administrator was terminated June 27, 2003. She believes it was because as regional administrator she attempted to bring order and accountability to employees who preferred to work amidst “chaos” and with “cubicles full of open case files.” She believes that as far as case work goes, “Nobody did anything wrong, sinister, or illegal.” She has not read the DCS report or kept up with department news since she left. The SIU did not contact her as part of its investigation, although they did interview the retired CPS director. The former

CPS director was named acting co-regional administrator July 2003 and regional administrator November 1, 2003.

## **D. On Operational Issues**

### **1. Reporting the Death of a Child**

According to DCS policy, all deaths of a child are to be reported immediately to the Incident Reviewer and to the Director of Child Protective Services. A Serious Incident Report must be faxed to the central office immediately if it is during working hours, or, if the death occurs on a holiday or weekend, by 9:00 am of the next working day. The regional administrator then forwards all relevant case files to the director of CPS via next-day delivery. We found that deaths in Shelby County may not have been consistently reported to the same individual in the central office.

Unfortunately, department staff said that sometimes in spite of all the steps taken by a case manager, the death of a child cannot be prevented. When this happens, it is critical that a team gathers information in the first 24 hours, before potential evidence is lost. According to the DCS investigation and our interviews, in some cases the caseworker did not interview siblings, follow up with the doctor to confirm or deny the story told by the family to explain the injuries, attempt to reenact the incident, or ask detailed questions to determine if the statements related to the deaths were accurate.

### **2. Interaction With Other Agencies**

The DCS investigation concluded that the system is inefficient because of the department's lack of community involvement and because the department does not align itself enough with community-based agencies like schools and churches. There were numerous complaints from outside agencies about the way DCS was unresponsive and tended not to listen to and work with other agencies.

### **3. Volume of Referrals**

Based on our interviews, it appears that the biggest hindrance to efficient and effective work may be the volume of referrals that come in. According to statistics provided by the Shelby County office, that location receives about 800 referrals a month to divide among 20 caseworkers. This averages about two per day per caseworker. Case managers say they cannot keep up with the referrals received and assert that the central intake screening process may be letting referrals through that do not merit further investigation. Another concern expressed by case managers is that a referral does not always lead to an assignment of a case to a case manager for follow-up. This is because of the large number of referrals and because of the turnover and inexperience of case managers. Case managers say they can usually meet the original response time required for a referral, but they often do not do the collateral work required of a case (interviews of people involved,

collection of evidence, and determining the perpetrator). Some caseworkers have been given cases before they have completed pre-service training.

The former regional administrator said that the former CPS director was reluctant to close cases, even if there was not a name or a phone number. In 2003, the regional administrator said she found cases dating back to 1999, far older than the 60-day maximum. She asked case managers to close at least ten cases each week or face disciplinary action. The former CPS director stated there was no reluctance to close cases during her tenure as CPS director. She explained that if cases were left open it was because there was not enough time to document the case visits or there were additional follow-up tasks to complete. She stated that during her tenure there was a push to get the cases closed because of the high numbers of cases open and coming in daily.

#### **4. TNKIDS**

Based on our review, it appears that because of deficiencies in TNKIDS, case managers use a paper system in parallel with the computerized case management system, but the two systems often contain inconsistent information about clients. Sometimes, because of time constraints or lack of organization, case activity is not promptly recorded in either location. The process of assigning referrals is such that it often created duplicate entries of cases in TNKIDS.

#### **5. Overtime**

A frequent complaint by many of the staff and management interviewed is that there just is not enough staff to do the work. The department allows overtime, with approval, because sometimes case managers cannot perform all the required case work in the time allotted. Lack of follow-up by case managers may be a factor in injuries or the death of a child.

#### **6. Lack of Supervisory Support**

In interviews that we conducted, department staff reported that under the previous regional administrator people got “dressed down” in public and employees were, and still are, scared of losing their jobs. There were numerous allegations of public verbal intimidation and abuse, foul language toward staff at all levels, threats by management, and promotions being unfairly distributed. Being on probation was used as a threat toward new employees. Case managers were sometimes given bad advice by their supervisor. When they sought to ask another supervisor for advice, the case manager would be labeled a “bad worker” or “trouble maker.” Therefore, a lot of consultation was done in secret. A number of workers thought they might lose their jobs or incur other hostilities from talking to the DCS investigators or to the auditors from State Audit. They felt that, “No matter what you do, you get punished.” Staff and management interviewed shared a perceived lack of support from the central office in Nashville for the operations in Shelby County.

## **7. Staff Qualifications**

Staff interviewed believed that some case managers, while they meet the minimum qualifications and want to work as case managers, cannot do the job. Tennessee requires a bachelor's degree, but other states require a bachelor's degree in social work. The DCS investigation concluded that there were inept case managers and that as a result of the Brian A. settlement agreement, and the accompanying staff reorganization, staff were promoted into positions for which they did not have proper experience. Additional concerns include high turnover and inadequate training, including supervisory training. As of July 2003, when the DCS interviews were conducted by the SIU, the total supervisor experience ranged from one week to 13 months. The total experience for all eight supervisors was four years and four and a half months.

Starting salaries in other states are higher, also. According to the November 2003 compliance report from the Brian A. court monitor, "The results of a consultant's study on compensation are that, 'Tennessee's compensation structure for case managers is lower than that of neighboring states and competitors within the State. Recommendations addressed issues such as increasing salaries through cost of living adjustments and merit pay increases and improving supportive resources for case managers through the hiring of additional case aides or administrative support staff. At this writing, DCS has not responded to the study recommendations.'"

## **E. Corrective Action Plan**

As part of our work, we assessed whether or not the department was implementing the changes described in the July 9, 2003, "Shelby County Region Corrective Action Plan," developed by DCS. We found that numerous case manager and supervisor training sessions have been held in Shelby County. We found, through interviews and documentation review, that numerous supervisory staff (team leaders and team coordinators) had been either moved from one section to another, demoted, or fired. The process for selection and hiring of staff changed after the DCS investigation was completed to allow supervisors to interview and contribute to decisions on hiring and assignments. Employees are allowed to sign in and out in their units, rather than at the regional administrator's office. Workers are not all required to be in the office on Wednesday. Of the 12 items listed in the corrective action plan, the department appears to be working on, or has completed, all 12. However, the permanent regional administrator was appointed November 1, 2003, not within 90 days, and the position of statewide director of Child Protective Services was replaced by "Director of Prevention and Protection," a filled position.

## **V. Recommendations**

### **A.**

The department should continue to implement the items listed in the corrective action plan, including improving working relationships with community-based agencies such as schools and hospitals, the local Child Advocacy Center, and law enforcement agencies.

### **B.**

The department may wish to revise the job requirements to more stringently define the person to be hired as a case manager. Education level, experience, and skill level should be considered. A higher-quality employee may require a higher level of compensation but should result in a lower turnover and better performance in case management duties.

### **C.**

Communication between the Shelby County regional office and the central office in Nashville must be improved in both directions. The Shelby County office must keep the central office informed about conditions and activities, especially in the case of the death of a child. In return, the central office must encourage and take steps to foster a more open and supportive environment for staff in its Shelby County operations.

The November 2003 Performance Audit of the Department of Children's Services contains additional concerns relating to staff qualifications and hiring (page 7), CPS investigation practices (page 40), and discrepancies between paper files and TNKIDS (page 41).