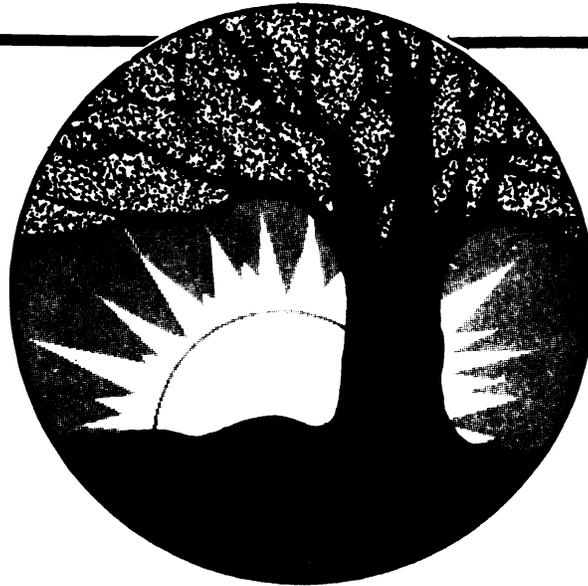


PERFORMANCE AUDIT

Department of Children's Services
Division of Child Protective Services
May 2007



John G. Morgan
Comptroller of the Treasury



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John G. Morgan
Comptroller

May 9, 2007

The Honorable Ron Ramsey
Speaker of the Senate
The Honorable Jimmy Naifeh
Speaker of the House of Representatives
The Honorable Thelma M. Harper, Chair
Senate Committee on Government Operations
The Honorable Mike Kernell, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of Department of Children's Services, Division of Child Protective Services. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the department should be continued, restructured, or terminated.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dww
07-028

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit
Department of Children's Services
Division of Child Protective Services
May 2007

AUDIT OBJECTIVES

The objectives of the audit were to assess the operations of the department's Child Protective Services Division, focusing on its investigations of children's deaths, and to recommend possible alternatives for legislative or administrative action.

FINDING

The Child Protective Services Division Does Not Completely Adhere to Policies and Procedures Governing Its Investigations of Children's Deaths

Based on a review of case documentation, the department did not complete child abuse investigations within 60 days in 50% percent of the cases reviewed; did not present 88% of indicated cases to the Child Abuse Review Team within 60 days; did not notify the juvenile court judge of intake cases or the investigation results in most cases; and did not notify the District Attorney General of indicated cases of severe child abuse in most cases reviewed. In addition, most case files did not have all required information. Without proper adherence to

policies and procedures for investigating children's deaths, the department risks jeopardizing these investigations, including determining the cause of death and perpetrator, if any (page 10).

OBSERVATIONS AND COMMENTS

The audit also discusses the following issues: data on children's deaths from the Department of Health that do not match similar data of the Department of Children's Services, cases with previous involvement with the Division of Child Protective Services, delays by outside parties in reporting allegations of abuse or neglect to the Division of Child Protective Services, and missing files for three cases selected for review (page 7).

Performance Audit
Department of Children’s Services
Division of Child Protective Services

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**Performance Audit
Department of Children's Services
Division of Child Protective Services**

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Department of Children's Services was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-227, the department was scheduled to terminate on June 30, 2006. On May 24, 2006, the General Assembly passed Public Chapter 1000, which extended this and other entities in the 2006 Sunset Cycle that had not yet been heard, for one year or until a public hearing can be held. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the department and to report the results to the Joint Government Operations Committee of the General Assembly. This performance audit is intended to aid the committee in determining whether the department should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to assess the operations of the department's Child Protective Services Division, focusing on its investigations of children's deaths;
2. to determine what measures, if any, the division could have taken to prevent these deaths;
3. to evaluate if the division has developed and implemented adequate procedures to determine the causes of deaths it investigates (e.g., through the review of autopsies and death certificates); and
4. to recommend possible alternatives for legislative or administrative action that may result in more efficient and effective operation of the division.

SCOPE AND METHODOLOGY OF THE AUDIT

We reviewed the activities and procedures of the department's Child Protective Services Division, focusing on its investigation of children's deaths that occurred from January 1, 2004, to September 30, 2006. The audit was conducted in accordance with the standards applicable to

performance audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. These methods included

1. review of applicable state legislation, and department rules, policies, and procedures;
2. examination of the department's records, reports, and information summaries;
3. analysis of information obtained from the federal government; and
4. interviews with department staff and federal government staff who interact with the Department of Children's Services.

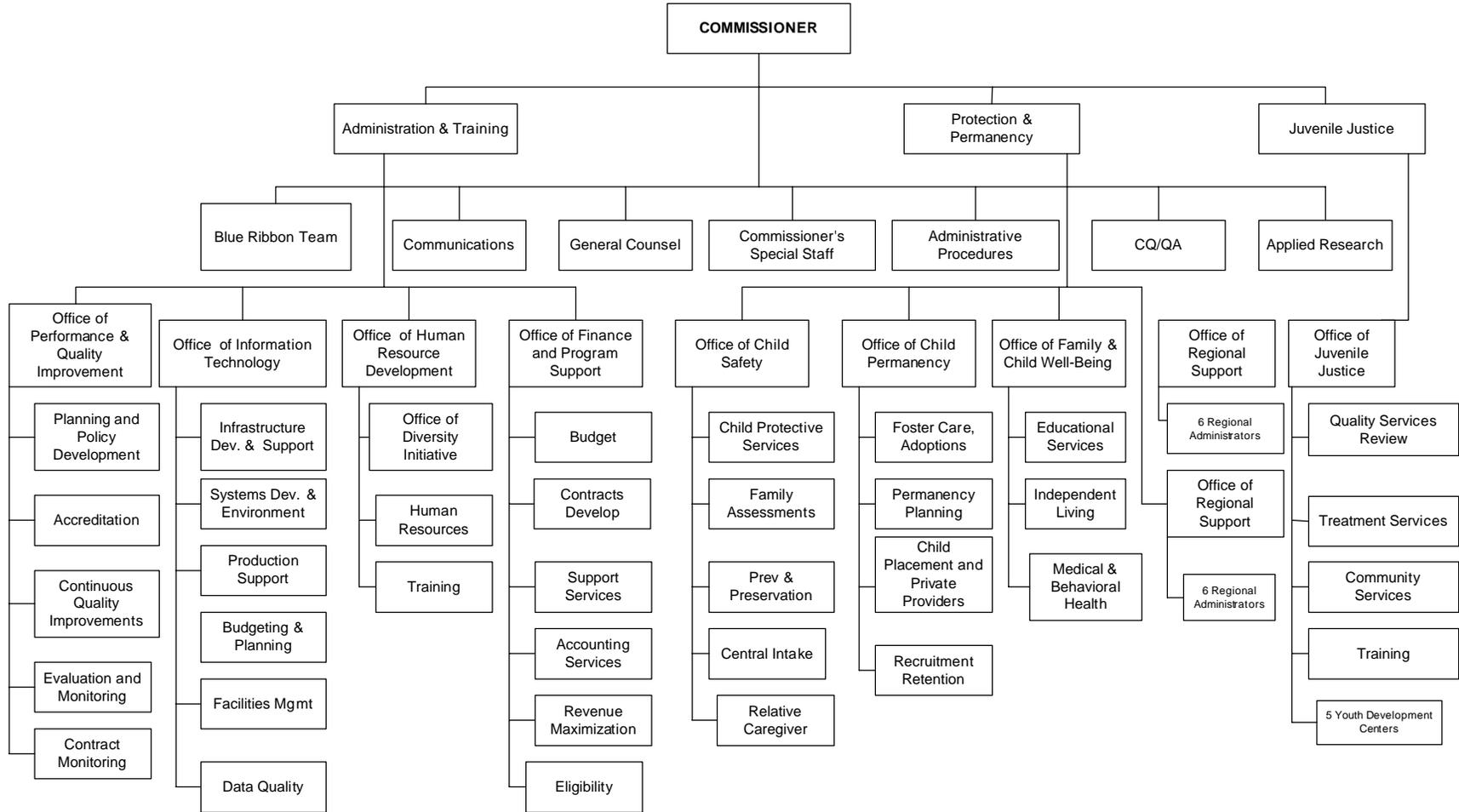
ORGANIZATION AND RESPONSIBILITIES

The Department of Children's Services (DCS) was created in July 1996 as the culmination of planning efforts begun in the early 1990s through an initiative, known as the Children's Plan, to improve coordination and delivery of services to children committed to state custody and to those at risk of entering state custody. It has approximately 5,000 employees and had a budget of \$600 million in fiscal year 2006. (See department's organization chart on page 3.) The Department of Children's Services, as authorized by Section 37-5-102, *Tennessee Code Annotated*, serves as the state's primary system for providing services to these at-risk children. DCS operations are organized into 12 regions. (See map on page 4.) Among the department's major responsibilities is ensuring that children under the age of 18 are safe and protected from abuse and neglect.

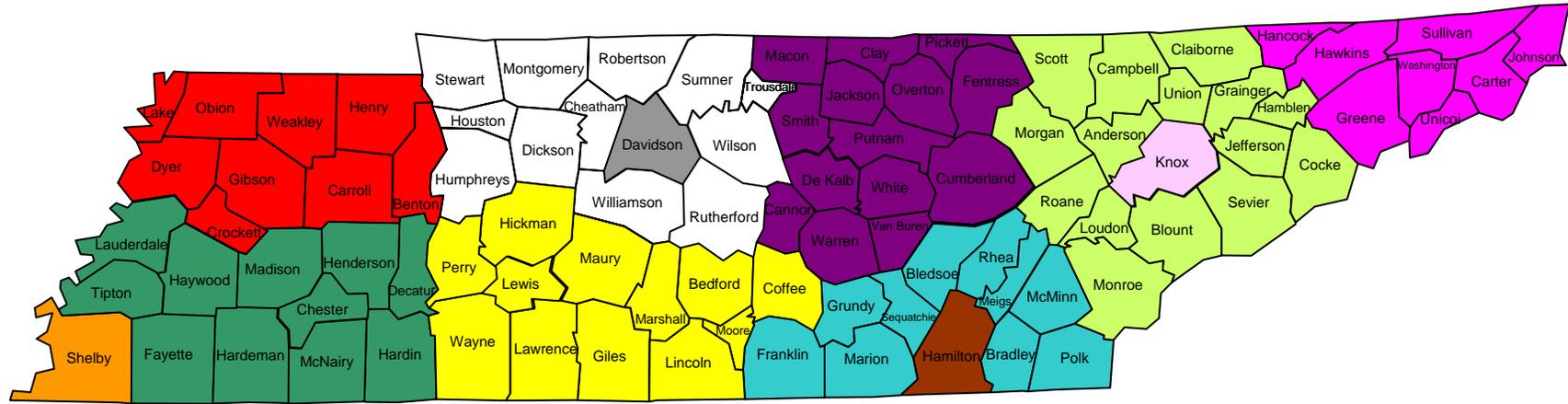
The Child Protective Services Division (CPS) is responsible for investigating allegations of abuse and neglect, assessing factors that brought the child and family to the attention of the department, working with the family to identify strengths and needs, connecting families with services, and determining whether the family can remain intact or if out-of-home placement is necessary. The division responds to over 37,000 reports of child abuse and neglect each year. Due to the seriousness of this issue, we focused our audit on CPS procedures.

We focused on CPS cases involving children's deaths that occurred from January 1, 2004, to September 30, 2006. There were a total of 153 deaths of which 59 were "indicated" (i.e., deaths determined by Child Protective Services to be caused by abuse and/or neglect). We selected for review all "indicated" deaths in seven Department of Children's Services regions, which we chose since they had the vast majority of deaths in the state. These regions had 77 percent of total deaths and 81 percent of indicated deaths. In addition, the seven regions represented Tennessee's three grand divisions, and urban and rural areas. We also chose to examine two cases in each region that were not indicated to determine whether it appeared CPS had made the right decision not to "indicate." We determined during our review that CPS appeared to have appropriately decided not to "indicate" in these cases. (See the flow chart on page 5 outlining the CPS process for investigating children's deaths.)

Department of Children's Services March 2007



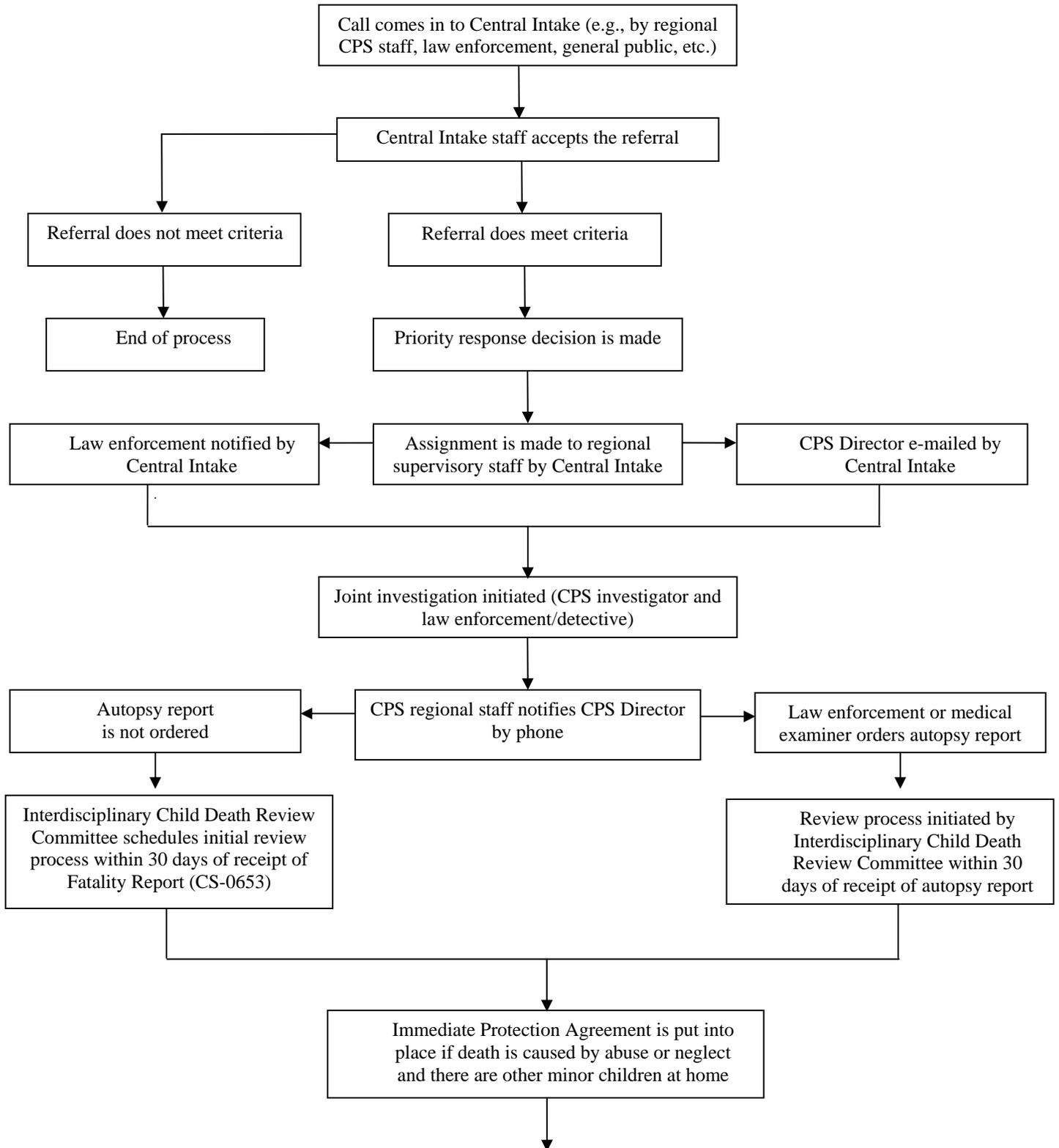
Department of Children's Services Regions

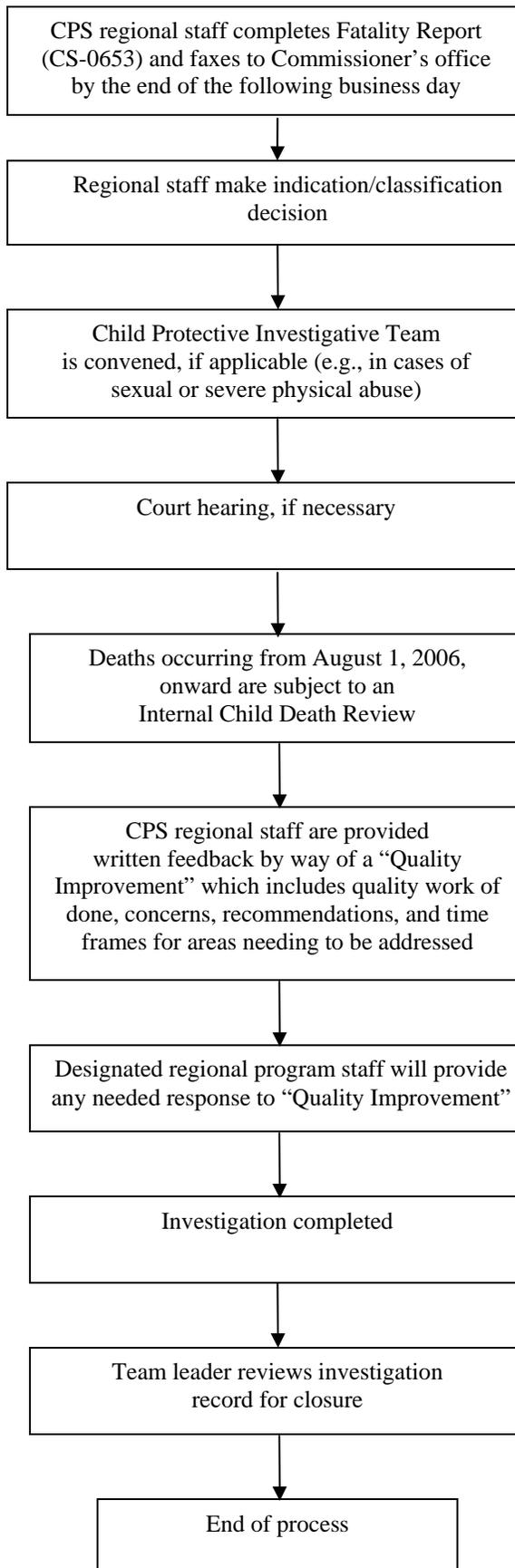


Department Regions

- Davidson County
- East Tennessee
- Hamilton County
- Knox County
- Mid-Cumberland
- Northeast
- Northwest
- Shelby County
- South Central
- Southeast
- Southwest
- Upper Cumberland

Child Protective Services Investigative Process For Child Deaths





**Number of CPS Cases Reviewed by Region
January 2004 Through September 2006**

	Davidson County	East Tennessee	Knox County	Mid- Cumberland	Shelby County	South Central	Southwest
All Indicated	4	4	3	9	18	5	5
Non- Indicated Sample	2	2	2	2	2	2	2*
Total	6	6	5	11	20	7	7*

* One case was actually processed in the Northwest Region (and was not reviewed), so total cases reviewed were 61 instead of 62. We had received information from the department before the file review that placed the case in the wrong region.

OBSERVATIONS AND COMMENTS

The issues discussed below are included in this report because of their effect on the operations of the Department of Children’s Services, specifically the Child Protective Services Division’s investigation of children’s deaths.

DATA ON CHILDREN’S DEATHS FROM THE DEPARTMENT OF HEALTH DO NOT MATCH SIMILAR DATA OF THE DEPARTMENT OF CHILDREN’S SERVICES

The Child Fatality Review and Prevention Act of 1995 (codified as Section 68-142-101, *Tennessee Code Annotated*, et seq.) established a statewide network of child fatality review teams under the Department of Health. These multi-discipline, multi-agency local teams have been established in the 31 judicial districts in Tennessee to review all deaths of children 17 years of age or younger. We requested from the Department of Health data on children’s deaths which occurred from January 1, 2004, to September 30, 2006, handled by its Child Fatality Review Program with Child Protective Services (CPS) involvement. Our purpose was to match similar information we had obtained from the Department of Children’s Services to ensure that we reviewed all the children’s deaths with CPS involvement for that period. Because of delays in processing data due to lag time in receiving documents such as death certificates, autopsies, and subsequent reports, the Department of Health was only able to provide us complete data for calendar years 2004 and 2005.

We determined after analyzing the sets of data from the two departments that there were significant discrepancies. For 2004, the Department of Children's Services listed 64 deaths and the Department of Health listed 70. There were only eight matching names between the two data sets. For 2005, the Department of Children's Services listed 95 deaths and the Department of Health listed 32 deaths. There were only seven matching names between these two sets. Without accurate information on the number of children's deaths that were investigated by CPS, the Department of Children's Services cannot ensure that all CPS investigations of children's deaths have been completed. In addition, the department cannot determine trends regarding causes of these deaths so as to take measures to prevent them.

The Commissioner should assign appropriate staff to reconcile differences in the data with the Department of Health regarding the number of child death cases handled by CPS. The staff should design and implement effective controls to prevent such discrepancies in the future. The assessment and the process of designing the controls should be fully documented and approved by the Commissioner.

PREVIOUS INVOLVEMENT WITH CHILD PROTECTIVE SERVICES

Auditors did not observe in the files a general pattern of Child Protective Services (CPS) staff failing to use available information to prevent a child's death. In the vast majority of the 61 child death cases we reviewed, CPS became involved in investigating the issues that caused the child's death only after the death. However, in several cases, the family of the child had previous interaction with CPS. In 14 (23 percent) of the 61 cases we reviewed, the family had previous involvement with CPS. In 6 of the 14 cases (43 percent, or ten percent of total cases), CPS determined that the previous allegations against the parents or adults were valid. (See Appendix 1 for a description of the circumstances of past involvement.)

In only one of the 61 cases were we able to determine that CPS might have been able to take actions to prevent a death. This case was one of the six cases with previous CPS involvement. According to case notes in the paper file, a police investigator stated to the case worker that the department had been negligent in not properly responding to a previous referral by a physician who had examined the child. The investigator stated that an unknown person from the department's Nashville office had told her that no safety plan was needed. The related CPS Intake Summary in the paper file stated that the physician had described bruises on the child "to be from hard play," contradicting the physician's allegation of "physical abuse," and thus CPS determined "no allegation of harm." The actual physician's description of the injuries was not on file so we could not determine why there was such a contradiction.

Although obviously not all proven allegations of neglect and/or abuse are conclusive proof that future children's deaths (or serious abuse and/or neglect) will occur, CPS should consider whether the assessment methods it uses can be improved to more accurately predict future harm to children involved in its investigations. The department should revise its assessment method to take into stronger consideration the allegations of professionals (e.g., physicians and psychologists) of physical and/or psychological abuse.

DELAYS IN REPORTING CASES TO CHILD PROTECTIVE SERVICES

Although the department cannot control delays by third parties in reporting allegations of abuse and/or neglect, we mention this issue because of the potential serious repercussions of such delays. In a case we reviewed which occurred in the East Tennessee Region, delays by the hospital to report the case may have resulted in the perpetrator not being charged with murder. A pregnant mother had been taking illegal drugs (e.g., amphetamines, methamphetamines, and opiates) resulting in the premature birth of her child. However, the hospital delayed reporting the death to CPS and law enforcement officials for three days, according to a law enforcement official. The police detective investigating the case stated that “the hospital dropped the ball on this case” and that the mother could not be charged “with anything.” The detective asserted that if an autopsy had been performed, the district attorney could have brought charges against the mother for second degree murder. Although CPS staff determined, through review of relevant information, the case was “indicated” (i.e., the mother was at fault for the death), only a law enforcement official could make a charge of homicide.

Late reporting to the department’s central intake was also a factor in three Shelby County cases. The three cases had 6-day, 95-day, and 191-day delays, respectively, from the time the death occurred to the time the department was informed of the death. We did not determine any negative repercussions for these delays, as none of the three cases were indicated; however, the faster a death is reported, the faster the department can investigate and determine whether abuse has occurred and review the status of other children in the family. In addition, Section 37-1-403, *Tennessee Code Annotated*, requires persons with knowledge of abuse or neglect to report it immediately to the department or local law enforcement officials. Section 37-1-412 makes failure to report a Class A misdemeanor. The department should consider taking steps to inform potential reporters of alleged child abuse and/or neglect of the need for prompt reporting of allegations so that any perpetrators are identified as soon as possible.

MISSING FILES

During our file review of the 61 cases, the department could not provide us sufficient documentation for 3 cases. One Davidson County case had its paper file missing while another Davidson County case had a paper file but no valuable information concerning the investigative process. A Knox County case had a paper file that only contained TNKids case recordings. (TNKids is the department’s management information system.) Our review of TNKids documentation did not reveal information lacking in paper files for any of the cases we reviewed. Without complete paper files, the department cannot document that it has completed all necessary investigative activities for each CPS case.

FINDING AND RECOMMENDATION

The Child Protective Services Division does not completely adhere to policies and procedures governing its investigations of children's deaths

Finding

We reviewed the paper investigative files of “indicated” deaths (i.e., deaths determined by Child Protective Services to be caused by abuse and/or neglect) in 7 of the 12 Department of Children’s Services regions, located in Tennessee’s three grand divisions and in both urban and rural areas. These regions are Davidson County, East Tennessee, Knox County, Mid-Cumberland, Shelby County, South Central, and Southwest. In each of these regions, we also reviewed two cases that were not “indicated” but were attributed to something other than natural causes (e.g., accidental drowning). All deaths occurred from January 1, 2004, to September 30, 2006. The seven regions had 77 percent of all child deaths investigated by Child Protective Services (CPS) and 81 percent of all indicated deaths for this period.

We performed the file review to determine if CPS staff adhered to all relevant procedures while investigating these deaths. In addition to adherence to these policies, we wanted to determine whether CPS staff obtained adequate information to determine cause of death, specifically autopsy reports, death certificates, and information on whether deaths were homicides. *Administrative Policies and Procedures*, 14.7 Classification and Closure of Child Protective Services Investigations, requires that investigations be formally documented, including documentation in paper files. We also reviewed TNKids data relating to these investigations to determine if information missing in paper files was in that computer system. TNKids is the department’s management information system. Without proper adherence to policies and procedures governing its investigations of children’s deaths, CPS staff risk compromising these investigations, including reducing the likelihood of determining the cause(s) of death in a timely manner.

We have summarized the results in tables below using the following seven categories.

- Intake activities
- Case investigation processing time
- Notification of internal/department parties
- Notification of outside parties
- Documentation of causes of death
- Severe child abuse and homicide
- File content

Intake activities

Administrative Policies and Procedures, 14.3 Screening, Assignment and Response Priority of Child Protective Services Cases, requires that reports “alleging the abuse and/or neglect of children shall be screened to determine the need for a CPS investigation and shall be either assigned for investigation in the appropriate jurisdiction or ‘screened out,’ and if assigned, shall be given a response priority based on the critical nature of the allegations of harm.” The policy gives Central Intake designated staff the role of screening each report alleging abuse and/or neglect, assigning a response priority, and making an assignment for investigation. Table 1 describes the three different priority codes Central Intake uses.

Table 1
Priority Code Descriptions

Priority Code	Description
Priority-1 (P-1)	Requiring <u>immediate response</u> , for referrals in which children may be in imminent threat of serious injury or death.
Priority-2 (P-2)	Requiring response two days (48 hours) after the report has been sent to the county for assignment. Reports that are assigned this priority will include any referrals that allege injuries or risk of injuries that are not life threatening or do not require immediate medical care.
Priority-3 (P-3)	Requiring response five working days after assignment. Reports that are assigned this priority will include any referrals that allege situations/ incidents that are considered to pose low risk of harm to the child.

According to *Administrative Policies and Procedures*, 14.1 Child Protective Services Risk Assessment, case managers and supervisors “shall consider the CPS risk factors at critical decision points in a case in order to assess family strengths and the risk of future harm to children. The *Child Protective Services Strength and Risk Assessment* (Form CS-0770) shall be used in all investigations except those involving residential, institutional, and substitute childcare facilities.” Obviously, this policy does not apply if there are no surviving children in the home. The CPS risk factors are described in Table 2. The case manager will then make an “overall risk rating” of either “high risk,” “intermediate risk,” “low risk,” or “no risk.” These categories of overall risk ratings are described in Table 3.

Table 2
CPS Risk Factors

Risk Factor Category	Description	Examples of Factors
Incident Factors	These factors provide a framework to assess the severity and frequency of the initial allegation reported to DCS.	<ul style="list-style-type: none"> a) Severity/frequency of abuse b) Location of the injury c) Severity/frequency of neglect
Child Factors	These factors focus on specific behaviors and conditions of the child. Strengths in these areas may reduce the level of overall risk, whereas problems in these areas could increase the overall level of risk.	<ul style="list-style-type: none"> a) Age and developmental status b) Perpetrator's access to child c) Child's presenting behavior
Primary Caretaker Factors	These factors focus on the behaviors and conditions of the child's primary caretaker. Strengths in these areas may reduce the level of overall risk, whereas problems in these areas could increase the level of risk.	<ul style="list-style-type: none"> a) Caretaker's attachment/ interaction with the child b) Knowledge of parenting skills c) Caretaker's history of maltreatment
Family/Environmental Factors	These factors are associated with strengths and risks in the total living environment.	<ul style="list-style-type: none"> a) Precipitating events/stressors b) Environmental conditions c) Availability of family support systems
Service Provision Factors	These factors are assessed after the family has received services to meet identified needs. They are designed to assess the family's progress in building strengths and resolution of risk.	<ul style="list-style-type: none"> a) Caretaker's participation or cooperation with agency staff and/or service plan b) Progress of child/family in treatment

**Table 3
Overall Risk Ratings**

Overall Risk Rating	Description
High Risk	The behaviors and the conditions present in the family suggest a threat of harm to the child and immediate action is needed in order to ensure the safety of the child. This action may include a removal of the child or engaging the family in a home-based service delivery program.
Intermediate Risk	There is sufficient cause to be concerned about the safety of the child, but the family has strengths that may enable them to reduce the risk through a change effort.
Low Risk	There are some concerns in the family that could eventually present risk to the child. Family may be engaged in a change effort on a voluntary basis.
No Risk	There were no identified risks in the family.

We found the following related information during the file review.

**Table 4
Intake Activities—All Regions**

Cases with P-1 Priority	49	80.3%
Cases with P-2 Priority	5	8.2%
Cases with P-3 Priority	1	1.6%
Cases with no priority	6	9.8%

Cases with risk assessment	45	73.8%
Cases with no risk assessment	10	16.4%
Cases not needing risk assessment*	6	9.8%

* No other children in home.

Considering that these cases dealt with children’s deaths, they should all have had a priority rating of P-1 as any other children in the home might be at risk. In the seven regions, the percentage of cases with a priority rating of P-1 ranged from 50 percent (Davidson County) to 100 percent (Shelby County). (See Appendix 2.) As indicated in Table 4, approximately 16 percent of cases did not have a risk assessment despite the fact that other children were in the home. In the seven regions, the percentage of cases with other children in the home and no risk assessment ranged from zero (East Tennessee and Southwest) to approximately 33 percent (Davidson County). (See Appendix 2.)

Case investigation processing time

Administrative Policies and Procedures, 14.7 Classification and Closure of Child Protective Services Investigations, requires that each CPS “investigation must be completed within 60 days of the date the report was received. This includes completing all required investigative activities, staffings with appropriate parties such as the Child Protective Investigative Team (CPIT) and the Child Abuse Review Team (CART), classifying the outcome of the allegations, documenting all case activities, and receiving approval by the team leader.” Section 37-1-406, *Tennessee Code Annotated*, mandates this 60-day deadline. However, the policy provides that if investigations exceed the 60-day deadline, “the team leader shall document in the TNKids case recording an explanation for the delay, along with a plan for completing the investigation as quickly as possible.”

According to Policy 14.7, each investigation by the CPIT will result in a classification indicating whether the allegation was justified and the alleged perpetrator(s) had caused the abuse and/or neglect. Cases can be classified in six different ways. The six classifications are described in Table 5.

**Table 5
Case Classifications
Child Protective Services Division**

Classification	Description
Allegation Indicated, Perpetrator Indicated	This classification is appropriate when there is sufficient information and evidence to support the opinion that: a) The alleged incident occurred or harmful situation existed, and b) The alleged perpetrator named in the report was found to be responsible for the child’s condition.
Allegation Indicated, Perpetrator Unfounded	This classification is appropriate when there is sufficient information and evidence to support the opinion that: a) The alleged incident occurred or harmful situation existed, but b) The alleged perpetrator named in the report was not found to be responsible for the child’s condition.
Allegation Indicated, Perpetrator Unknown	This classification is appropriate when there is sufficient information and evidence to support the opinion that: a) The alleged incident occurred or harmful situation existed, but b) No alleged perpetrator was named in the report or identified through the investigation. c) If the case involves a removal prior to classifying, case managers shall confer with regional legal staff to ensure that all resources have been exhausted to reach a conclusion regarding the identity of the alleged perpetrator(s). Additional support services may be obtained through central office.

Classification	Description
Allegation Unfounded, Perpetrator Unfounded	This classification is appropriate when: a) There is insufficient information and evidence to support the opinion that the alleged incident occurred or harmful situation existed, and b) The alleged perpetrator named in the report was not found to be responsible for the reported maltreatment.
Allegation Indicated, Sexually Reactive Child	This classification is appropriate when: a) There is sufficient information and evidence to support the opinion that sexual contact did occur, but b) The dominant figure in that contact was a child under the age of ten (10) years.
Unable to Complete	This classification is appropriate when: a) The case manager is unable to locate the alleged victim and his or her family in spite of good faith efforts to find them, or b) The incident occurred in another state and DCS participated in investigative activities or offered services, but has no ability or authority to formally identify a perpetrator.

We determined that, on average, case investigations exceeded the 60-day deadline by over 7 days. (See Table 6.) Six of the 61 cases had no evidence of a CPS determination of the cause of death in their paper files or in TNKids. In the seven regions, average investigation times ranged from approximately 48 days (Shelby County) to approximately 102 days (Davidson County). (See Appendix 3.) There was no evidence in TNKids case recordings explaining the causes for each delay, “along with a plan for completing the investigation as quickly as possible,” as required by Policy 14.7.

Table 6
Case Investigation Processing Time
All Regions

Average investigation time (days)	67.5	
Cases meeting investigations 60-day deadline	24	39.3%
Cases not meeting investigations 60-day deadline	31	50.8%
Cases with no evidence of determining the cause of death*	6	9.8%

* In 3 cases there was no evidence of CPS staff determining the cause of death. In 3 other cases there was evidence of police investigative activity.

Notification of the Child Abuse Review Team

Case workers, in addition to reporting to their supervisors, must report case information to other parties within the department, including the Child Abuse Review Team (CART). *Administrative Policies and Procedures*, 14.7 Classification and Closure of Child Protective Services Investigations, requires that all “indicated cases of child abuse must be presented to the Child Abuse Review Team (CART) for its review and recommendations prior to the end of the sixty day (60) time frame for investigation” by CPS staff. The case manager must document in TNKids the date each case was reviewed by CART, CART recommendations, actions taken by CPS staff in response to these recommendations, and explanations why any recommendations were not followed. Since cases referred to CART have already been classified as “indicated,” CART does not determine whether child abuse has occurred. (See page 14 for a description of the classification process involving the Child Protective Investigative Team.)

Very few of the cases we reviewed were reported to the CART. Case workers presented only approximately 12 percent of indicated cases to CART prior to the end of the 60-day investigative deadline. (See Table 7.) In the seven regions, the percentage of cases reported to CART ranged from zero (Davidson County, Knox County, Mid-Cumberland, and South Central) to 25 percent (East Tennessee and Southwest). (See Appendix 4.)

Table 7
Notification of Child Abuse Review Team (CART)
All Regions

Notification Status	Cases	Percent
Indicated cases presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	5	11.9%
Indicated cases not presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	37	88.1%

Notification of outside parties: juvenile court judges and district attorneys

According to *Administrative Policies and Procedures*, 14.2 Child Protective Services Intake Decisions, the “Department of Children’s Services (DCS) shall receive reports alleging child abuse or neglect to protect the safety of children, to ensure the confidentiality of persons who report abuse or neglect, to gather sufficient information to determine whether children may be at risk of abuse or neglect, and to inform the Juvenile Court authorities... .” The policy requires each county/region to notify the juvenile court judge daily “in each judicial jurisdiction of all child abuse and intake reports.”

Administrative Policies and Procedures, 14.7 Classification and Closure of Child Protective Services Investigations, requires that the case manager “provide the juvenile court with a complete written and signed summary of the results of every child abuse and neglect

investigation within seven (7) days after the classification decision “on the CPS Investigation Summary and Classification Decision of Child Abuse/Neglect Referral (Form CS-0740). The case manager must document in TNKids when this form was sent to the juvenile court. Policy 14.7 also requires that the case manager “provide the district attorney general with a written summary of the results of every indicated severe child abuse investigation within seven (7) days after the investigative classification decision has been made” on Form CS-0740. The case manager must document in TNKids when this form was sent to the district attorney general.

In the vast majority of cases, department staff did not meet these requirements to notify these outside parties. In only approximately ten percent of cases was the juvenile court judge notified through the intake process, and in only approximately seven percent of cases was the judge notified within seven days of classification. In only approximately 11 percent of “severe child abuse” indicated cases was the district attorney general notified within seven days of classification. (See Table 8.)

In the seven regions, the percentage of cases that were reported to the juvenile court judge during intake ranged from zero (Davidson County, East Tennessee, and Knox County) to approximately 33 percent (Southwest). (See Appendix 5.) The percentage of cases that were reported to the judge within seven days of classification ranged from zero (Davidson County, Mid-Cumberland, South Central, and Southwest) to approximately 33 percent (East Tennessee and Knox County). (See Appendix 5.) The percentage of “severe child abuse” indicated cases reported to the district attorney within seven days of classification ranged from zero (Mid-Cumberland, Shelby County, South Central, and Southwest) to approximately 67 percent (East Tennessee). (See Appendix 5.)

Table 8
Notification of Outside Parties
All Regions

Notification Status	Cases	Percent
Juvenile Court judge notified through intake information	6	9.8%
Juvenile Court judge not notified through intake information	55	90.2%
<hr/>		
Juvenile Court judge notified within 7 days of classification*	4	7.4%
Juvenile Court judge not notified within 7 days of classification	50	92.6%
<hr/>		
District Attorney General notified within 7 days of classification, if indicated “severe child abuse”	4	11.1%
District Attorney General not notified within 7 days of classification, if indicated “severe child abuse”	32	88.9%

* Seven cases were not classified.

Documentation of causes of death

We wanted to determine during the file review of both paper files and TNKids data whether CPS staff obtained adequate information to determine cause of death, specifically through the use of autopsy reports and death certificates. *Administrative Policies and Procedures*, 14.7 Classification and Closure of Child Protective Services Investigations, requires that “the case manager shall obtain and maintain in the office a copy of other pertinent documents pertaining to each specific case.” Such documents should include any “other documents obtained in the course of the investigation.” *Administrative Policies and Procedures*, 20.29 Death of Child/Youth in Department of Children’s Services Custody, requires autopsies for children who died from August 1, 2006, onward while in CPS custody when the children died from unexplained or unnatural causes, or when there is a public health concern (no cases we reviewed met this requirement for an autopsy). Most cases we reviewed had no autopsies, and death certificates were even less likely to be in case files, as shown in Table 9.

Table 9
Documentation of Causes of Death
Cases From January 2004 Through September 2006

Region	Autopsies	Death Certificates	Total Cases
	In Case File (Percent of Cases)	In Case File (Percent of Cases)	
Davidson County	16.7%	16.7%	6
East Tennessee	50.0%	0.0%	6
Knox County	60.0%	20.0%	5
Mid-Cumberland	36.4%	18.2%	11
Shelby County	20.0%	0.0%	20
South Central	14.3%	0.0%	7
Southwest	16.7%	0.0%	6
Total	27.9%	6.6%	61

Severe child abuse and homicide

Administrative Policies and Procedures, 14.7 Classification and Closure of Child Protective Services Investigations, requires that the case manager “determine if each indicated allegation meets the criteria for severe child abuse.” The case manager will document this determination on the CPS Investigation Summary and Classification Decision of Child Abuse/Neglect Referral (Form CS-0740) and on TNKids screens. We were interested in determining the relationship between severe child abuse and homicides. Specifically, we wanted to know whether severe child abuse was a good predictor of homicide. As indicated in Table 10, the likelihood of a severe child abuse victim also becoming a homicide victim is very high. In our file review, the majority of cases involved death as a result of severe child abuse. Over half of

these severe child abuse victims also were homicide victims, as declared by law enforcement officials.

Table 10
Severe Child Abuse and Homicide
Cases From January 2004 Through September 2006

Region	Severe Child Abuse*		Homicides*		Total Cases Reviewed
	Cases	Percent of Cases	Cases	Percent of Cases	
Davidson County	2	33.3%	2	33.3%	6
East Tennessee	3	50.0%	3	50.0%	6
Knox County	2	40.0%	1	20.0%	5
Mid-Cumberland	8	72.7%	3	27.3%	11
Shelby County	15	75.0%	9	45.0%	20
South Central	3	42.9%	1	14.3%	7
Southwest	3	50.0%	2	33.3%	6
Total	36	59.0%	21	34.4%	61

* A determination of “severe child abuse” is made by Child Protective Services staff while only a law enforcement official can make a charge of homicide.

File content

Administrative Policies and Procedures, 14.7 Classification and Closure of Child Protective Services Investigations, requires that investigations be formally documented, including documentation in paper files. Table 11 lists the official forms and other documentation that should be present in paper investigative files.

The vast majority of files we reviewed were not complete. (See Table 12.) The most common documents that were missing were copies of notification cover letters sent to the Juvenile Court, District Attorney General, the professional reporter, and the indicated perpetrator(s). To a lesser extent, files were missing Forms CS-0561 (Child Protective Services Investigative Review), CS-0740 (Child Protective Services Investigation Summary and Classification Decision of Child Abuse/Neglect Referral), and CS-0770 (Child Protective Services Strength and Risk Assessment).

**Table 11
Required Documentation in Paper Investigative Files**

Official Forms	Other Documents
<p>The following forms and information shall be completed and included in the CPS investigative file:</p> <p>a) Form CS-0561, Child Protective Services Investigative Review to document the findings of the Child Protective Investigative Team</p> <p>b) Form CS-0740, Child Protective Services Investigation Summary and Classification Decision of Child Abuse/Neglect Referral to document the classification decision</p> <p>c) Form CS-0770, Child Protective Services Strength and Risk Assessment to document the risk issues</p>	<p>In addition to official forms, the case manager shall obtain and maintain in the office a copy of other pertinent documents pertaining to each specific case. Such documents may include:</p> <p>a) Verification of medical findings</p> <p>b) Report of psychological evaluation or treatment</p> <p>c) Reports from any other service providers</p> <p>d) Photographs and audio and video tapes</p> <p>e) A signed Authorization/Consent for Release of Information</p> <p>f) Copies of notification cover letters sent to the Juvenile court, District Attorney General, the professional reporter, and the indicated perpetrator(s)</p> <p>g) Any other documents obtained in the course of the investigation.</p>

**Table 12
Child Death Cases Reviewed
January 2004 Through September 2006**

File Content

Region	Files Complete	Files Incomplete	All Files	Percent of Files Complete
Davidson County	0	6	6	0.0%
East Tennessee	1	5	6	16.7%
Knox County	1	4	5	20.0%
Mid-Cumberland	0	11	11	0.0%
Shelby County	0	20	20	0.0%
South Central	0	7	7	0.0%
Southwest	0	6	6	0.0%
Total	2	59	61	3.3%

Recommendation

The Commissioner should take steps to ensure that Child Protective Services staff completely adhere to all policies and procedures governing investigations of children's deaths.

These steps should ensure that all children's deaths brought to the attention of Child Protective Services undergo a complete investigation.

The Commissioner should amend *Administrative Policies and Procedures*, 20.29 Death of Child/Youth in Department of Children's Services Custody, to require autopsies for all children who died from unexplained or unnatural causes, or when there is a public health concern, whether or not the children were in Child Protective Services' custody at the time of death. The department should amend *Administrative Policies and Procedures*, 14.7 Classification and Closure of Child Protective Services Investigations, to specifically require copies of these autopsies in paper investigative files.

The Commissioner should require the appropriate staff to assess the risk that the Child Protective Services program may fail to achieve all its goals, including those goals noted in this finding. The staff should then design and implement effective controls to mitigate that risk. The assessment and the process of designing the controls and linking them to specific risks should be fully documented and approved by the Commissioner.

Management's Comment

We concur. Please note that we concur with the finding as stated, "The Child Protective Services Division does not completely adhere to policies and procedures governing its investigation of children's deaths." The referenced policies governing investigations of child deaths include standards for presentation and notification of case activity. As noted, in the finding, we do not always adhere to what is outlined in policy. However, we would like to note that given sufficient time the Department of Children's Services is able to verify that there are county/regional procedures in place to ensure that presentation and notification of cases occur. We recognize and acknowledge that county/regional practice is not always documented in a clear and concise manner.

We will work towards reconciling statewide policy and regional procedure as recommended, as well as, ensuring adequate documentation. The Child Protective Services Division requested the recommended amendments to *Administrative Policies and Procedures 20.29, Death of Child/Youth in Department of Children's Services Custody* and *Administrative Policies and Procedures 14.7 Classification and Closure of Child Protective Services Investigations* on Friday, May 04, 2007. Requests were made through our Division of Planning and Policy Development.

The Division of Child Protective Services will, also, review and revise notification procedures in relation to the Courts, District Attorneys and CART no later than May 18, 2007.

- There are some regions included in this audit that have a practice of combining CPIT and CART. The combining of these two teams is not in violation of current policy.
- Regional staff use CS-0561 *Child Protective Investigative Team Review* form to document whether CPIT and CART were combined and note recommendations of CART

(see page 2 of CS-0561 “If CART and CPIT are combined, please note CART Treatment Recommendations and date reviewed”).

It should, also, be noted that the aforementioned form CS-0561 *Child Protective Investigative Team Review* documents case classification staffing and notification of District Attorneys (DA) of case classification. The DA is a member of the CPIT and is required to sign the form, as are other members.

In addition, it should be noted that whereas the audit report states that juvenile court judges were notified of intakes in only 10% of the cases reviewed, the Department of Children’s Services would like to note:

- In some of the regions reviewed, the court authorities have requested a system of notification which includes submitting weekly and monthly logs documenting intakes for their judicial counties/regions.

Furthermore, it should be noted that whereas the audit report states the juvenile court judges were notified of classification in only 7% of the cases reviewed, the Department of Children’s Services is able—given sufficient time—to produce documentation to verify a system in which copies of CS-0740 *Child Protective Services Investigative Summary and Classification Decision of Child Abuse/Neglect Referral* are submitted to the court on a routine basis.

Likewise, there were six files noted as having neither a priority response assigned nor evidence of determining cause of death. Given additional time, the Department would like the opportunity to demonstrate that there was no priority response assigned and no evidence determining cause of death due to the probability that referenced fatalities did not meet the department’s standards for investigative involvement (i.e. fatalities due to natural causes).

We will ensure that additional focus is placed on providing pre-service and in-service training on policies and procedures—including amendments—governing investigations of child deaths no later than August 2007. Technical assistance regarding investigation of child deaths will be requested no later than May 14, 2007. The Department will, also, provide focused training for staff regarding effective documentation. We recognize that timely, accurate and complete documentation is a practice that must be improved throughout our agency. We, also, recognize and acknowledge that effective documentation has been a challenge for our staff. However, we believe our process of self-assessment and preparation for the Council on Accreditation will yield much improvement in this and other areas of our work.

Finally, in response to audit finding 1, a Risk Management Plan will be developed for the Child Protective Services Program. This plan will be submitted to the Commissioner for review and approval no later than May 31, 2007.

RECOMMENDATIONS

ADMINISTRATIVE

The Department of Children's Services should address the following areas to improve the efficiency and effectiveness of its operations.

1. The Commissioner of the Department of Children's Services should take steps to ensure that Child Protective Services staff completely adhere to all policies and procedures governing investigations of children's deaths. These steps should ensure that all children's deaths brought to the attention of Child Protective Services undergo a complete investigation.
2. The Commissioner should amend *Administrative Policies and Procedures*, 20.29 Death of Child/Youth in Department of Children's Services Custody, to require autopsies for all children who died from unexplained or unnatural causes, or when there is a public health concern, whether or not the children were in Child Protective Services' custody at the time of death. The department should amend *Administrative Policies and Procedures*, 14.7 Classification and Closure of Child Protective Services Investigations, to specifically require copies of these autopsies in paper investigative files.
3. The Commissioner should require the appropriate staff to assess the risk that the Child Protective Services program may fail to achieve all its goals, including those goals noted in this finding. The staff should then design and implement effective controls to mitigate that risk. The assessment and the process of designing the controls and linking them to specific risks should be fully documented and approved by the Commissioner.
4. The Commissioner should assign appropriate staff to reconcile differences in the data with the Department of Health regarding the number of child death cases handled by CPS. The staff should design and implement effective controls to prevent such discrepancies in the future. The assessment and the process of designing the controls should be fully documented and approved by the Commissioner.

Appendix 1
Previous Child Protective Services Involvement in Cases Reviewed

Case	Previous Allegations Valid?	Description of Previous CPS Involvement	Death Indicated?	Date of Death
1	Yes	Several referrals before death including 3/22/04, 7/03/04, 8/15/04, and 8/25/04. Most of allegations were lack of supervision/drug exposed child/psychological harm/physical abuse. The allegations against the mother for lack of supervision and substantial risk of physical injury were founded. The child had been in DCS custody but in runaway status from a contracted mental health facility at the time of death.	No	2/23/2005
2	No	A previous Priority 3 referral involved allegations of “lack of supervision” of children in the family. The referral was on 7/3/03 and the case was closed on 12/6/03.	Yes	7/7/2004
3	Yes	All the mother’s other children were already in custody of relatives at the time of the death of the child. The mother had a history of drug abuse.	Yes	7/15/2006
4	No	The formal paper file of this case could not be found. However, the auditor was given a paper file containing what appeared to be TNKids printouts indicating previous CPS involvement. The printouts did not have evidence of any founded allegations as a result of this involvement.	Yes*	1/15/2005
5	No	A Priority 3 case had been open for another child in the family on 9/27/04. Case was closed due to lack of evidence with an Allegation Unfounded/Perpetrator Unfounded classification for physical abuse.	Yes	11/24/2004
6	No	In a Priority 3 case initiated on 4/09/04, the mother was found Allegation/ Unfounded Perpetrator Unfounded on an allegation of lack of supervision of other children, before the child in this case was born.	Yes	8/9/2006
7	Yes	In a past case involving the mother (opened on 4/02/04), the staff reviewed allegations for lack of supervision (not indicated), nutritional neglect (indicated), and substantial risk of physical injury (indicated). For the indicated allegations, staff indicated “No” for severe abuse. Another case was opened on 7/30/04 against the mother on an allegation of substantial risk of physical injury which was determined to be unfounded. Another case opened on 9/22/04 involving alleged sexual abuse by a non-relative was determined unfounded on 11/10/04. A medical report was on file supporting this conclusion.	Yes	11/13/2005

**Previous Child Protective Services Involvement in Cases Reviewed
(Continued)**

Case	Previous Allegations Valid?	Description of Previous CPS Involvement	Death Indicated?	Date of Death
8	Yes	On 3/3/03 (in a case opened on 2/19/03), staff determined that the mother had committed physical abuse of another child, despite information the department gave us that there had been no interaction with CPS within two years of death.	No	4/4/2004
9	No	In a referral on 4/4/05, the birth mother was the alleged perpetrator due to involvement in a domestic dispute with one of her children's fathers. The case was "unfounded" as the mother moved to a safe location with her children and the case was closed on 5/4/05.	Yes	8/15/2006
10	No	A Priority 2 investigation started on 7/19/05 regarding an allegation of sexual and physical abuse against an unknown alleged perpetrator. The alleged victim was a child of the father by another mother. The classification of this case was Unable to Complete.	Yes	1/25/2006
11	No	Child had been released from DCS custody on 12/23/04. She had been placed on state probation on 9/29/04 for five counts of Burglary to Vehicles and four counts of Theft of Property.	No**	12/29/2004
12	Yes	A previous CPS investigation alleging the physical abuse of the child was opened on 2/17/04 and was closed on 8/03/04. There appeared to be no severe abuse regarding the parents even though the case was classified "UABC" (Unable to Complete). There are two other children in the home. Approximately one year prior to the death of the child, CPS found that the mother had physically abused an older sibling.	Yes	5/18/2005
13	Yes	Case notes indicated the mother, the perpetrator, had been involved in two previous CPS investigations, one in June 2001 for lack of supervision of a three-year-old (placed in the custody of paternal grandparents), and one in 2002 for drug exposed child, which was unfounded.	Yes	4/9/2004
14	No	There was a previous referral on 7/12/04 by a physician who had examined the child, which was unfounded. The allegation had been physical abuse.	Yes	7/30/2004

* Death "indicated" in spreadsheet provided by the department, but no there was no supporting documentation in either paper file or TNKids.

** Death not "indicated" in spreadsheet provided by the department, but there was no supporting documentation in either paper file or TNKids.

Appendix 2
CPS Intake Activities by Region
Child Death Cases Reviewed — January 2004 Through September 2006

Intake Activities – Davidson County		
Cases with P-1 Priority	3	50.0%
Cases with P-2 Priority	1	16.7%
Cases with P-3 Priority	0	0.0%
Cases with no priority	2	33.3%
Cases with risk assessment	4	66.7%
Cases with no risk assessment	2	33.3%
Cases not needing risk assessment*	0	0.0%

* No other children in home.

Intake Activities – East Tennessee		
Cases with P-1 Priority	4	66.7%
Cases with P-2 Priority	2	33.3%
Cases with P-3 Priority	0	0.0%
Cases with no priority	0	0.0%
Cases with risk assessment	4	66.7%
Cases with no risk assessment	0	0.0%
Cases not needing risk assessment*	2	33.3%

* No other children in home.

Intake Activities – Knox County		
Cases with P-1 Priority	3	60.0%
Cases with P-2 Priority	1	20.0%
Cases with P-3 Priority	0	0.0%
Cases with no priority	1	20.0%
Cases with risk assessment	3	60.0%
Cases with no risk assessment	1	20.0%
Cases not needing risk assessment*	1	20.0%

* No other children in home.

Intake Activities – Mid Cumberland		
Cases with P-1 Priority	9	81.8%
Cases with P-2 Priority	0	0.0%
Cases with P-3 Priority	1	9.1%
Cases with no priority	1	9.1%
Cases with risk assessment	10	90.9%
Cases with no risk assessment	1	9.1%
Cases not needing risk assessment*	0	0.0%

* No other children in home.

Appendix 2 (continued)
CPS Intake Activities by Region
Child Death Cases Reviewed — January 2004 Through September 2006

Intake Activities — Shelby County		
Cases with P-1 Priority	20	100.0%
Cases with P-2 Priority	0	0.0%
Cases with P-3 Priority	0	0.0%
Cases with no priority	0	0.0%
Cases with risk assessment	14	70.0%
Cases with no risk assessment	4	20.0%
Cases not needing risk assessment*	2	10.0%

* No other children in home.

Intake Activities — South Central		
Cases with P-1 Priority	5	71.4%
Cases with P-2 Priority	1	14.3%
Cases with P-3 Priority	0	0.0%
Cases with no priority	1	14.3%
Cases with risk assessment	5	71.4%
Cases with no risk assessment	2	28.6%
Cases not needing risk assessment*	0	0.0%

* No other children in home.

Intake Activities — Southwest		
Cases with P-1 Priority	5	83.3%
Cases with P-2 Priority	0	0.0%
Cases with P-3 Priority	0	0.0%
Cases with no priority	1	16.7%
Cases with risk assessment	5	83.3%
Cases with no risk assessment	0	0.0%
Cases not needing risk assessment*	1	16.7%

* No other children in home.

Appendix 3
Case Investigation Processing Time by Region
Child Death Cases Reviewed — January 2004 Through September 2006

Case Investigation Processing Time – Davidson County		
Average investigation time (days)	101.8	
Cases meeting investigations 60-day deadline	0	0.0%
Cases not meeting investigations 60-day deadline	4	66.7%
Cases with no evidence of determining the cause of death	2	33.3%

Case Investigation Processing Time – East Tennessee		
Average investigation time (days)	94.0	
Cases meeting investigations 60-day deadline	2	33.3%
Cases not meeting investigations 60-day deadline	4	66.7%
Cases with no evidence of determining the cause of death	0	0.0%

Case Investigation Processing Time – Knox County		
Average investigation time (days)	76.7	
Cases meeting investigations 60-day deadline	0	0.0%
Cases not meeting investigations 60-day deadline	3	60.0%
Cases with no evidence of determining the cause of death *	2	40.0%

* One of two cases had evidence of a police investigation.

Case Investigation Processing Time – Mid-Cumberland		
Average investigation time (days)	60.6	
Cases meeting investigations 60-day deadline	5	45.5%
Cases not meeting investigations 60-day deadline	5	45.5%
Cases with no evidence of determining the cause of death investigations*	1	9.1%

* This case had evidence of a police investigation

Case Investigation Processing Time – Shelby County		
Average investigation time (days)	48.3	
Cases meeting investigations 60-day deadline	12	60.0%
Cases not meeting investigations 60-day deadline	8	40.0%
Cases with no evidence of determining the cause of death	0	0.0%

Appendix 3 (continued)
Case Investigation Processing Time by Region
Child Death Cases Reviewed — January 2004 Through September 2006

Case Investigation Processing Time – South Central		
Average investigation time (days)	67.2	
Cases meeting investigations 60-day deadline	2	28.6%
Cases not meeting investigations 60-day deadline	4	57.1%
Cases with no evidence of determining the cause of death *	1	14.3%

* This case had evidence of a police investigation.

Case Investigation Processing Time – Southwest		
Average investigation time (days)	89.5	
Cases meeting investigations 60-day deadline	3	50.0%
Cases not meeting investigations 60-day deadline	3	50.0%
Cases with no evidence of determining the cause of death investigations*	0	0.0%

* One file was actually investigated in the Northwest Region and thus was not included.

Appendix 4
Notification of the Child Abuse Review Team (CART) by Region
Child Death Cases Reviewed — January 2004 Through September 2006

Notification of Child Abuse Review Team (CART) – Davidson County		
Notification Status	Cases	Percent
Indicated cases presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	0	0.0%
Indicated cases not presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	3	100.0%

Notification of Child Abuse Review Team (CART) – East Tennessee		
Notification Status	Cases	Percent
Indicated cases presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	1	25.0%
Indicated cases not presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	3	75.0%

Notification of Notification of Child Abuse Review Team (CART) – Knox County		
Notification Status	Cases	Percent
Indicated cases presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	0	0.0%
Indicated cases not presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	2	100.0%

Notification of Child Abuse Review Team (CART) – Mid-Cumberland		
Notification Status	Cases	Percent
Indicated cases presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	0	0.0%
Indicated cases not presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	8	100.0%

Notification of Child Abuse Review Team (CART) – Shelby County		
Notification Status	Cases	Percent
Indicated cases presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	3	17.6%
Indicated cases not presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	14	82.4%

Appendix 4 (continued)
Notification of the Child Abuse Review Team (CART) by Region
Child Death Cases Reviewed — January 2004 Through September 2006

Notification of Child Abuse Review Team (CART) – South Central		
Notification Status	Cases	Percent
Indicated cases presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	0	0.0%
Indicated cases not presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	4	100.0%

Notification of Child Abuse Review Team (CART) – Southwest		
Notification Status	Cases	Percent
Indicated cases presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	1	25.0%
Indicated cases not presented to the Child Abuse Review Team (CART) prior to end of 60-day investigative deadline	3	75.0%

Appendix 5
Notification of Outside Parties by Region
Child Death Cases Reviewed — January 2004 Through September 2006

Notification of Outside Parties – Davidson County		
Notification Status	Cases	Percent
Juvenile Court judge notified through intake information	0	0.0%
Juvenile Court judge not notified through intake information	6	100.0%
Juvenile Court judge notified within 7 days of classification*	0	0.0%
Juvenile Court judge not notified within 7 days of classification	4	100.0%
District Attorney General notified within 7 days of classification, if indicated "severe child abuse"	1	50.0%
District Attorney General not notified within 7 days of classification, if indicated "severe child abuse"	1	50.0%

* Two cases were not classified.

Notification of Outside Parties – East Tennessee		
Notification Status	Cases	Percent
Juvenile Court judge notified through intake information	0	0.0%
Juvenile Court judge not notified through intake information	6	100.0%
Juvenile Court judge notified within 7 days of classification	2	33.3%
Juvenile Court judge not notified within 7 days of classification	4	66.7%
District Attorney General notified within 7 days of classification, if indicated "severe child abuse"	2	66.7%
District Attorney General not notified within 7 days of classification, if indicated "severe child abuse"	1	33.3%

Notification of Outside Parties – Knox County		
Notification Status	Cases	Percent
Juvenile Court judge notified through intake information	0	0.0%
Juvenile Court judge not notified through intake information	5	100.0%
Juvenile Court judge notified within 7 days of classification*	1	33.3%
Juvenile Court judge not notified within 7 days of classification	2	66.7%
District Attorney General notified within 7 days of classification, if indicated "severe child abuse"	1	50.0%
District Attorney General not notified within 7 days of classification, if indicated "severe child abuse"	1	50.0%

* Two cases were not classified.

Appendix 5 (continued)
Notification of Outside Parties by Region
Child Death Cases Reviewed — January 2004 Through September 2006

Notification of Outside Parties – Mid-Cumberland		
Notification Status	Cases	Percent
Juvenile Court judge notified through intake information	2	18.2%
Juvenile Court judge not notified through intake information	9	81.8%
Juvenile Court judge notified within 7 days of classification*	0	0.0%
Juvenile Court judge not notified within 7 days of classification	10	100.0%
District Attorney General notified within 7 days of classification, if indicated "severe child abuse"	0	0.0%
District Attorney General not notified within 7 days of classification, if indicated "severe child abuse"	8	100.0%

* One case was not classified.

Notification of Outside Parties – Shelby County		
Notification Status	Cases	Percent
Juvenile Court judge notified through intake information	1	5.0%
Juvenile Court judge not notified through intake information	19	95.0%
Juvenile Court judge notified within 7 days of classification	1	5.0%
Juvenile Court judge not notified within 7 days of classification	19	95.0%
District Attorney General notified within 7 days of classification, if indicated "severe child abuse"	0	0.0%
District Attorney General not notified within 7 days of classification, if indicated "severe child abuse"	15	100.0%

Notification of Outside Parties – South Central		
Notification Status	Cases	Percent
Juvenile Court judge notified through intake information	1	14.3%
Juvenile Court judge not notified through intake information	6	85.7%
Juvenile Court judge notified within 7 days of classification*	0	0.0%
Juvenile Court judge not notified within 7 days of classification	5	100.0%
District Attorney General notified within 7 days of classification, if indicated "severe child abuse"	0	0.0%
District Attorney General not notified within 7 days of classification, if indicated "severe child abuse"	3	100.0%

* Two cases were not classified.

Appendix 5 (continued)
Notification of Outside Parties by Region
Child Death Cases Reviewed — January 2004 Through September 2006

Notification of Outside Parties – Southwest		
Notification Status	Cases	Percent
Juvenile Court judge notified through intake information	2	33.3%
Juvenile Court judge not notified through intake information	4	66.7%
Juvenile Court judge notified within 7 days of classification	0	0.0%
Juvenile Court judge not notified within 7 days of classification	6	100.0%
District Attorney General notified within 7 days of classification, if indicated "severe child abuse"	0	0.0%
District Attorney General not notified within 7 days of classification, if indicated "severe child abuse"	3	100.0%