STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

TENNESSEE DEPARTMENT OF CHILDREN'S SERVICES AND SECOND LOOK COMMISSION

Performance Audit Report

November 2016

Justin P. Wilson, Comptroller

Division of State Audit
Sunset Performance Section

DEBORAH V. LOVELESS, CPA, CGFM, CGMA
Director

JOSEPH SCHUSSLER, CPA, CGFM
Assistant Director

SANDRA TULLOSS
Audit Manager

Nichole Crittenden, CGFM, CFE
M. Vincent Finamore, CFE
Lisa Williams, CGFM, CFE
David Wright, CFE
In-Charge Auditors

Dean Agouridis, CGFM
Janora Bryson
Jaclyn Clute
Ricky Ragan, CFE
Sarah Vandergriff
Staff Auditors

Amy Brack
Editor

Amanda Adams
Assistant Editor

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building
Nashville, TN 37243-1402
(615) 401-7897

Reports are available at
www.comptroller.tn.gov/sa/AuditReportCategories.asp

Mission Statement
The mission of the Comptroller's Office is to make government work better.

Comptroller Website
www.comptroller.tn.gov

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT
SUITE 1500, JAMES K. POLK STATE OFFICE BUILDING
505 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-1402

PHONE (615) 401-7897
FAX (615) 532-2765

November 30, 2016

The Honorable Ron Ramsey
Speaker of the Senate
The Honorable Beth Harwell
Speaker of the House of Representatives
The Honorable Mike Bell, Chair
Senate Committee on Government Operations
The Honorable Jeremy Faison, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and

The Honorable Bonnie Hommrich,
Commissioner
Department of Children's Services
UBS Tower, 10th Floor
315 Deaderick Street
Nashville, Tennessee 37243
and
The Honorable Craig Hargrow, Director
Second Look Commission
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Department of Children's Services and the Second Look Commission. 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 of Children's Services and the Second Look Commission should be continued, restructured, or terminated.

Sincerely,

Deborah V. Loveless

Deborah V. Loveless, CPA
Director

16110

State of Tennessee

Audit Highlights

Comptroller of the Treasury Division of State Audit

Performance Audit
Department of Children's Services
and
Second Look Commission
November 2016

We audited the Department of Children's Services and the Second Look Commission's activities for the period February 1, 2014, through September 30, 2016. Our audit scope included a review of internal controls and compliance with laws, regulations, and provisions of contracts or grant agreements related to our audit objectives. Management of the department and the commission is responsible for establishing and maintaining effective internal controls and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient, appropriate audit evidence to support the conclusions in our report. We present more detailed information about our methodologies in the individual report sections.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

DEPARTMENT OF CHILDREN'S SERVICES

Juvenile Justice (pages 10-15)

Finding 1 Incident reporting needs to be more timely

To assess whether the department's incident reporting data is reliable, auditors tested the department's incident reporting process. We found the department did not consistently adhere to policy time guidelines when entering incidents into the Tennessee Family and Child Tracking System (TFACTS). Auditors reviewed all incident reports from a sample of three Youth Detention Center working days to determine if they were handled according to policy and were submitted within timelines dictated in department policy. We found that 80% of incident reports were not submitted in a timely manner (page 13).

The audit also discusses the department's substantial actions to address security incidents (page 12).

Child Safety and Programs (pages 16-30)

Finding 2 A significant number of investigation files were missing key documentation required by department policy, which opens the possibility that the investigations might not have been completed thoroughly or as timely as possible

DCS policies require key documents to be maintained in hard case files or TFACTS. Auditors conducted an in-depth review of electronic and paper documentation for 60 high priority investigations from three regions across the state. Our review found files missing key documentation and some investigations not classified or closed in a timely manner. Insufficient investigations can lead to negative child outcomes if critical information is not available when courts and the department make critical decisions about a child's safety (page 20).

Finding 3 A Child Protective Investigative Team Advisory Board has been formed, but the board has not developed statewide protocols

The Child Protective Investigative Team (CPIT) Advisory Board was created in 2014 to help CPITs work more consistently and effectively across the state. However, as of June 2016, the committee has not yet developed statewide protocols needed to help ensure CPIT effectiveness and consistency. In part, the board has been hindered by low attendance (page 26).

The audit also discusses that the Child Abuse Hotline referred most reports to the local investigative unit in a timely manner, but that it lacked some tools that would be helpful to analyze the process (page 27).

Administrative Functions, including the department's computerized case tracking system (pages 31-44)

Finding 4 The department has taken steps to improve TFACTS; however, the department still had not implemented remaining recommendations from the prior audit

In August 2010, the department implemented a new child welfare information system called the Tennessee Family and Child Tracking System (TFACTS). Since inception, users reported various issues with the system. In our 2014 audit, we reviewed TFACTS and determined that the department needed to improve upon seven areas related to the system.

Based on our review in this audit, we found that the department made numerous changes to TFACTS to adequately address our prior recommendations and continues to make improvements to the system. However, users reported they still had difficulty using the system's search function and continued to experience slow speeds and logouts while using TFACTS. We also found that some of the financial functions in TFACTS were still not operating correctly, so staff continued to conduct financial processes outside of the system (page 34).

The audit also discusses the department's progress in addressing contracted foster care network adequacy, but due to the fluidity of the process, the department should take measures to ensure continuity (page 39).

SECOND LOOK COMMISSION

Finding 1 The Second Look Commission complied with statute, but its impact is inherently limited

While the Second Look Commission (SLC) complied with its statutory mandate, its impact is limited because it reviewed a relatively small number of cases. In fiscal year 2014, SLC reviewed only approximately 2% of the previous year's eligible cases, well below the 10% maximum. As a result of these small sample sizes, SLC's impact is limited because its results may not be truly indicative of widespread problems. The SLC needs to identify and consider other ways to increase its ability to review additional cases, such as setting aside additional review time. SLC recommendations based on more case reviews can provide DCS and other stakeholders more valid and likely more pervasive, issues hampering case management. Additionally, there is no formal mechanism to ensure its recommendations are shared with key stakeholders, especially those outside state government (page 45).

Performance Audit
Department of Children's Services

TABLE OF CONTENTS

		Page
INTRODUCTION		1
Purpose and Authority for the Audit		1
Audit Scope		1
Audit Objectives and Methodology		2
DEPARTMENT OF CHILDREN'S SERVICES		3
Statutory Responsibilities and Organization		3
Juvenile Justice		10
Prior Audit Findings		10
Current Audit Results		12
Observation 1	The department took substantial actions to address security incidents	12
Finding 1	Incident reporting needs to be more timely	13
Child Safety and Programs		16
Prior Audit Findings		18
Current Audit Results		20
Finding 2	A significant number of investigation files were missing key documentation required by department policy, which opens the possibility that the investigations might not have been completed thoroughly or as timely as possible	20
Finding 3	A Child Protective Investigative Team Advisory Board has been formed, but the board has not developed statewide protocols	26

TABLE OF CONTENTS (Continued)

		Page
Observation 2	The Child Abuse Hotline refers most reports to the local investigative unit in a timely manner, but lacks some tools that would be helpful to analyze the process	27
Administrative Functions		31
Prior Audit Findings		31
Current Audit Results		34
Finding 4	The department has taken steps to improve TFACTS; however, the department still has not implemented remaining recommendations from the prior audit	34
Observation 3	The department has made progress in addressing contracted foster care network adequacy, but due to the fluidity of the process, the department should take measures to ensure continuity	39
SECOND LOOK COMMISSION		45
Organization and Statutory Responsibilities		45
Audit Results		45
Finding 1	The Second Look Commission complied with statute, but its impact is inherently limited	45
APPENDICES - DEPARTMENT OF CHILDREN'S SERVICES		53
Appendix 1 - Title VI and Other Information		53
Appendix 2 - Performance Measures Information		59
Appendix 3 - Budget Information		60
Appendix 4 -Youth Development Center Incident Reporting SFY 2015-2016		61

TABLE OF CONTENTS (Continued)

	Page
Appendix 5 - Providers by Location and Gender Served	66
APPENDICES – SECOND LOOK COMMISSION	71
Appendix 6 - Section 37-3-804, *Tennessee Code Annotated*, Membership	71
Appendix 7 - Members as of October 31, 2016	73
Appendix 8 - Fiscal Year 2015 Expenditures	74

Performance Audit
Department of Children's Services
and
Second Look Commission

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Department of Children's Services and the Second Look Commission was conducted pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29, *Tennessee Code Annotated*. Under Section 4-29-238, the department and commission are scheduled to terminate June 30, 2017. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the department and commission and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the committee in determining whether the department and the commission should be continued, restructured, or terminated.

AUDIT SCOPE

We audited the department's and the commission's activities for the period February 1, 2014 through September 30, 2016. Our audit scope included a review of internal controls and compliance with laws, regulations, and provisions of contracts or grant agreements related to our audit objectives. Management of the Department of Children's Services and the Second Look Commission is responsible for establishing and maintaining effective internal controls and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient, appropriate audit evidence to support the conclusions in our report. We present more detailed information about our methodologies in the individual report sections.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

AUDIT OBJECTIVES AND METHODOLOGY

Our objectives for this audit were to

- review the department's Child Abuse Hotline referral process and determine how the department monitors the efficiency and effectiveness of call documentation and case assignments;
- determine the department's efforts to assess the adequacy of its provider network with regard to identifying service gaps and how the department monitors those providers for service delivery;
- determine the department's efforts to identify and address security risks within the Juvenile Justice facilities (i.e., escapes as well as the risk of assaults by residents on other residents and on department staff);
- gather general information for inclusion in the report, such as the process of assessing children in the department's Juvenile Justice system;
- determine whether the commission is meeting statutory requirements;
- review the commission's process for case selection and review;
- gather information about commission recommendations made to the Department of Children's Services and the Tennessee General Assembly as a result of reviews; and
- follow up on prior audit findings.

To meet these objectives, we focused our work on department functions:

- Juvenile Justice (pages 10-15),
- Child Safety and Programs (pages 16-30), and
- Administrative Functions, including the department's computerized case tracking systems (pages 31-44).

Additionally, we reviewed the commission in its entirety.

Our audit work included assessments of internal controls and compliance with laws, rules and regulations, and policies through interviews, surveys, observations, inspection of documents and records, and direct tests, such as file reviews. Each finding or observation will contain additional information on specific methodologies used for the resulting conclusions.

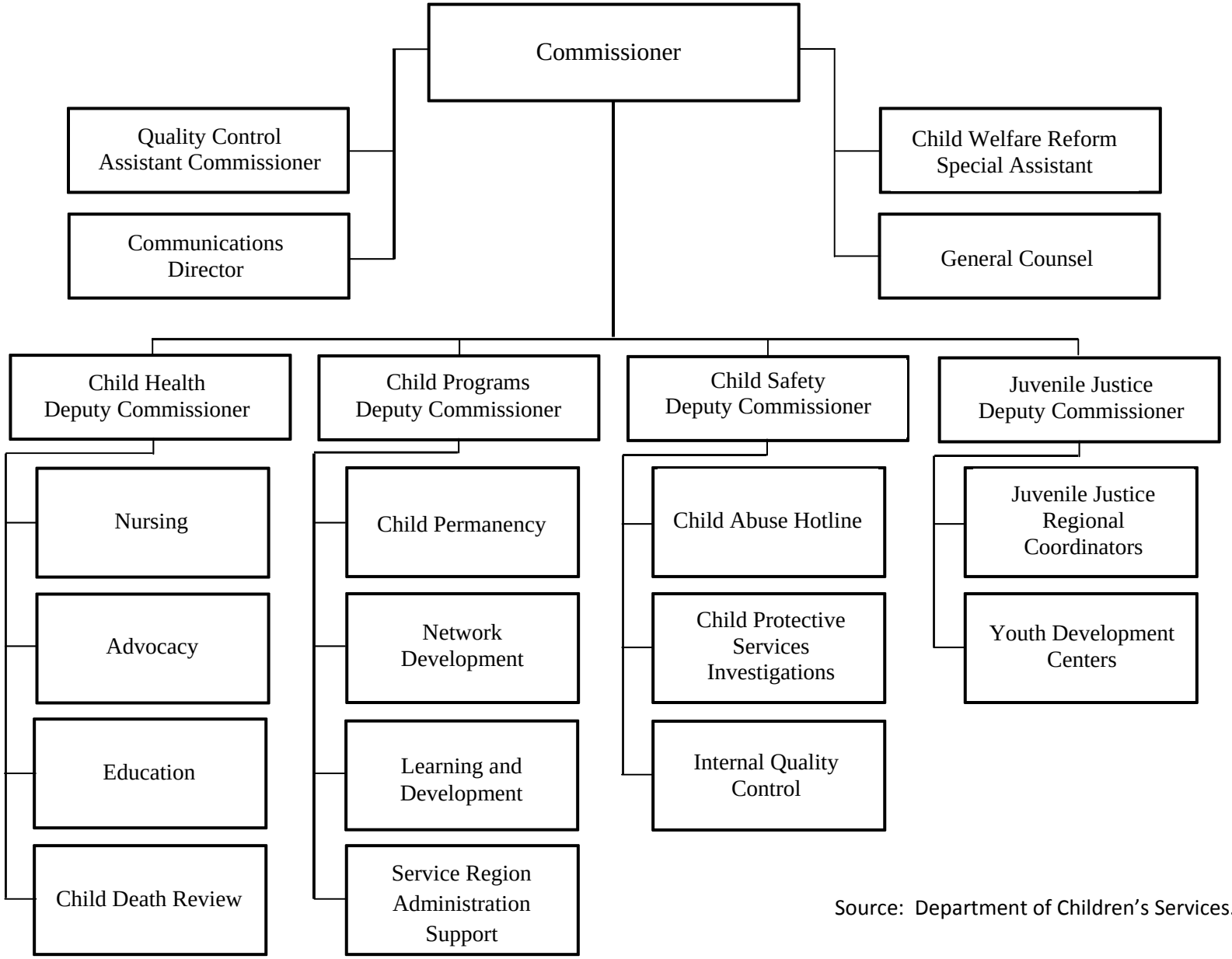
DEPARTMENT OF CHILDREN'S SERVICES

STATUTORY RESPONSIBILITIES AND ORGANIZATION

The Department of Children's Services was created in July 1996 as part of the Children's Plan initiative to provide services to children in state custody or at risk of entering state custody. Section 37-5-102, *Tennessee Code Annotated*, authorizes the department to serve as the state's primary system for providing services to Tennessee's most-at-risk children. According to the Department of Children's Services' *Strategic Plan 2014-2016*, the department's mission is to ensure "forever families for children and youth by delivering high-quality, evidence-based services in partnership with the community." There were 7,977 children in the department's custody as of August 16, 2016, including 196 children in Youth Development Centers. The department had approximately 3,900 employees in August 2016.

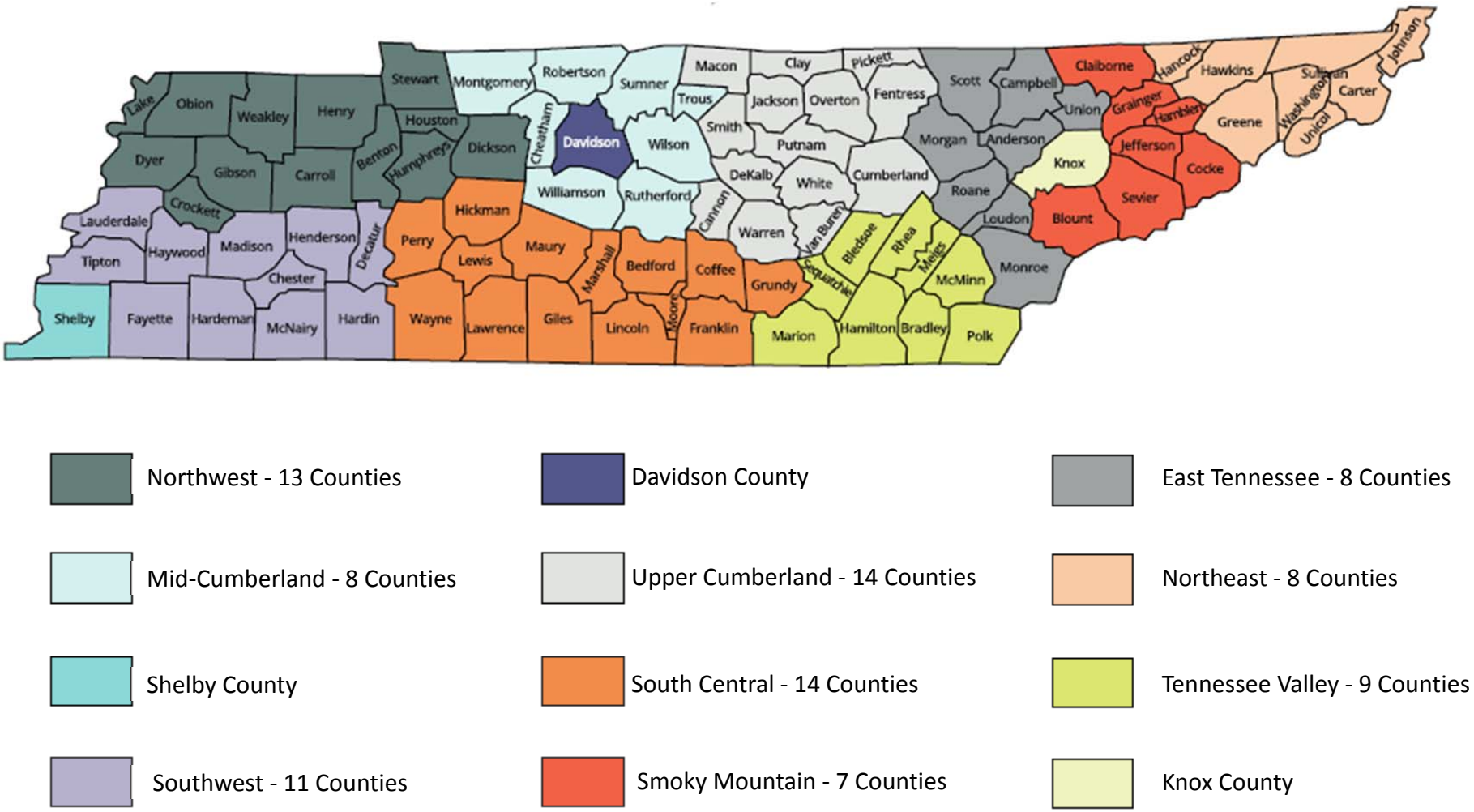
In order to accomplish its mission, the Department of Children's Services is organized into four main offices: Child Health, Child Safety, Child Programs, and Juvenile Justice (see organization chart on page 4). The department's operations are organized into 12 regions across Tennessee (see map on page 5).

Organizational Chart
Department of Children's Services
As of August 2016



Source: Department of Children's Services.

Department of Children's Services
Regions as of June 2016



Northwest - 13 Counties

Davidson County

East Tennessee - 8 Counties

Mid-Cumberland - 8 Counties

Upper Cumberland - 14 Counties

Northeast - 8 Counties

Shelby County

South Central - 14 Counties

Tennessee Valley - 9 Counties

Southwest - 11 Counties

Smoky Mountain - 7 Counties

Knox County

Source: Auditor's Analysis of information provided by Department of Children's Services.

Office of Child Health

The Office of Child Health is responsible for the physical and mental health of the children it serves, while also ensuring their educational success. The Department of Children's Services is the TennCare managed care contractor and the local education agency for children in state custody and the office uses child health nurses, health advocates, and education specialists to fulfill its responsibilities.

Child health nurses serve to support family service workers, parents/guardians, foster parents, and service providers with guidance and technical assistance in navigating the health care system. These nurses review and interpret medical records and treatment plans for children who require medical intervention, and work with TennCare regarding the provision of services, accessibility issues, and case management services for children in state custody.

The Health Advocacy Unit sponsors the Crisis Management Team and coordinates the network of Centers of Excellence for Children In or At Risk of State Custody. The Crisis Management Team assists TennCare-eligible children who have been denied residential mental health treatment by their TennCare managed care organization and may be at risk of state custody due to the denial of the service. Centers of Excellence are academic medical centers, provider agencies, and partners possessing expertise in children's physical and behavioral health. Health advocates also ensure children receive needed health services, including ensuring children and families are notified of the right to appeal any changes in services and ensuring non-TennCare-eligible services are available through private providers.

Education specialists, working in conjunction with children's caseworkers, oversee early childhood interventions, help students acclimate to new schools, help youth enroll in college, and advocate for all children in the classroom and in meetings with birth families, foster parents, caseworkers and providers. Additionally, education specialists ensure that children achieve a smooth transition to different school districts and receive needed special education services to help them succeed in school and after they leave foster care or juvenile detention. The education staff works with more than 140 Tennessee school districts and 38 provider-run schools, and is responsible for operating the DCS Special School District in the Youth Development Centers to ensure students in detention meet all state-mandated requirements.

Office of Child Safety

The Office of Child Safety is responsible for the intake and screening of reports of child abuse and neglect to determine if they meet the criteria to be investigated, and conducting these investigations. Specifically, the Child Abuse Hotline receives initial reports through telephone calls and a public website. Child Protective Services investigators conduct fieldwork to assess whether the allegations are justified and the children involved are safe. They coordinate their work with law enforcement, child advocacy centers, and prosecutors.

To assess allegations of abuse and neglect, the Office of Child Safety uses its Multiple Response System which helps staff to determine the severity of the alleged maltreatment, and takes into account a family's needs. These assessments allow Child Protective Services case

managers to offer a variety of approaches that can be more helpful to families than a traditional, more restrictive investigative approach, and promise more lasting, beneficial change. For example, a family may need and receive counseling to avoid future problems.

Office of Child Programs

The Office of Child Programs' main goal is to maintain children in their homes if their homes are safe and appropriate, but provide safe placement and adequate care for children who cannot remain in their homes. The office has programs in two general categories:

- custodial, for children in Department of Children's Services custody, such as foster care, adoption, and independent living; and
- non-custodial, for children not in custody, such as family preservation services.

Custodial Programs

Custodial care programs include foster care, adoption, and independent living. Foster care is intended to be a temporary placement until the family, and in some cases the child, can resolve the problems that made placement necessary. An alternative to traditional foster care parents are relative caregivers, who must be related to the child by blood, marriage, or adoption. The child must reside in the home with the relative caregiver. When parents cannot, or will not, make their home safe for the child's return, program staff seek other permanent options.

Adoption may be such a solution. According to the department's *Adoption Best Practices Manual*, the purpose of adoption is

> to provide permanent, safe, and loving homes for children by legally transferring parental responsibilities from birth/legal parents to adoptive parents. The best interest of the child should be reflected in every decision made for children with a permanency goal of adoption.

Before a child can be adopted, parental rights must be legally surrendered or severed making the child available for adoption. A court also must approve the adoption.

As older children "age out" of state custody and become adults, independent living services make the transition to adulthood as smooth as possible to enable these children to lead fulfilled, productive lives. Caseworkers are responsible for developing tailored independent living plans for custodial youth ages 14 to 16. These detailed plans outline specific actions to help the youth acquire independent living and social skills such as shopping, cooking, doing laundry, managing money, developing resumes, learning job interview skills, practicing effective communication, and building relationships. At age 17, caseworkers create an individualized transition plan with specific actions to achieve the skills needed for a successful adulthood for each child. These skills include social skills (connections to supportive/caring adults), housing, physical and mental health, employment, education, finances, communication, and transportation.

Non-custodial Programs

Non-custodial programs are designed to safeguard and enhance the welfare of children not in state custody by preserving family life and enhancing parents' abilities to parent their children. Child Protective Services' staff and juvenile courts can refer children for services.

The Office of Child Programs has two community-based child abuse prevention programs:

Nurturing Parenting Program: This family-centered initiative is designed to build nurturing parenting skills as an alternative to abusive and neglectful parenting and child-rearing practices. The program includes a wide variety of modules designed for specific at-risk populations including teen parents, military families, parents and caregivers of disabled children, first-time parents, and parents/caregivers recovering from substance abuse. Services include in-home and grouped-based classes.

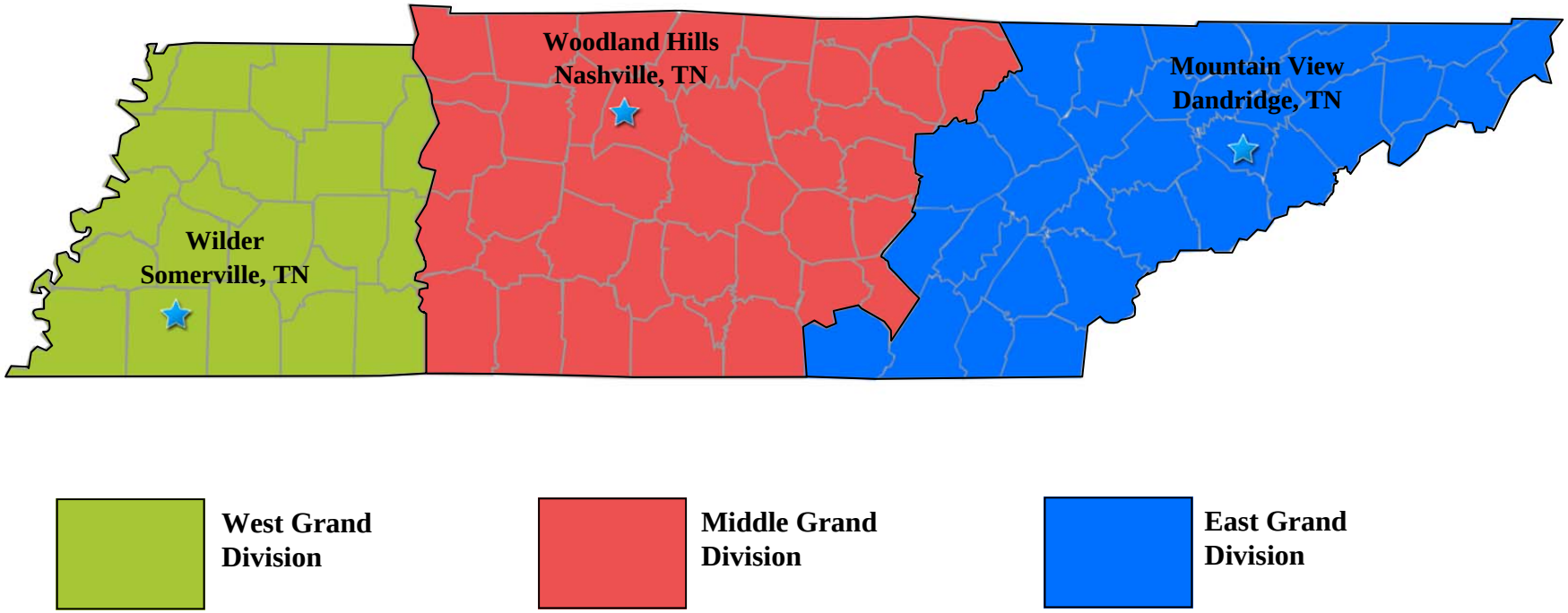
Darkness to Light's Stewards of Children: This evidence-training program designed to prevent sexual abuse, educates adults to recognize, prevent, and react responsibly to child sexual abuse and motivates caregivers to courageous action. This three-hour discussion-based training is administered by trained facilitators.

Office of Juvenile Justice

This office addresses the needs of youth who have been adjudicated delinquent after breaking the law. The most serious offenders typically go to one of Tennessee's three Youth Development Centers (see map on page 9). In general, these youth have committed at least three felonies, and it has been determined that community safety requires that they be placed in settings that are designed to be escape-proof. However, the majority of youth served do not need highly restricted placements and are served by a network of community-based facilities around the state. These private-provider facilities offer specialized services, including those designed to deal with substance abuse problems and conduct disorders. Section 37-5-121, *Tennessee Code Annotated*, requires these programs' effectiveness to be evidence-based, meaning that they have been proven successful.

We interviewed departmental staff at the central office and at each of the department's Youth Development Centers (YDCs). We also reviewed departmental documents and conducted a file review of incidents in each of the YDCs to determine whether the incidents were entered into the Tennessee Family and Child Tracking System (TFACTS) within the time frame required by department policy.

Department of Children's Youth Development Centers By Grand Division



(Source: Auditor's analysis of information provided by the Department of Children's Services and Grand Divisions as defined by Section 4-1-201 through 204, *Tennessee Code Annotated.*

JUVENILE JUSTICE

PRIOR AUDIT FINDINGS

Section 8-4-109, *Tennessee Code Annotated*, requires each state department, agency, or institution to report to the Comptroller of the Treasury actions taken to implement audit recommendations. We conducted a follow-up of findings from the most recently issued performance audit (January 2014). We found that the department addressed the 2014 recommendations related to Juvenile Justice as follows:

Follow-up – 2014 Audit Finding 8: "The department is not meeting probation and aftercare supervision requirements for youth who have been adjudicated delinquent"

The audit recommended that the department should take steps to ensure that the caseworkers adequately supervise youth who have been adjudicated delinquent and are on probation and aftercare, and that they properly perform Youth Level of Service/Case Management Inventory assessments or reassessments according to departmental policy. These steps should include retraining on these policies for Juvenile Justice caseworkers. Additionally, these caseworkers should be adequately supervised and monitored by their team leaders and coordinators.

We found the department instituted controls to monitor Juvenile Justice. Specifically, the department developed reports monitoring whether Family Service Workers are meeting minimum contact requirements with youth. The department also developed assessment timeliness reports.

It is unclear whether the department retrained all personnel. The department formally trains newly hired Juvenile Justice staff on relevant policies for probation and aftercare supervision. However, the department did not capture, and thus could not provide auditors, consistent, easily accessible, statewide documentation that existing staff received similar retraining, especially when that retraining was informal. Without such documentation, neither the department nor the auditors can ensure this retraining occurred.

The 2014 finding is partially resolved.

Follow-up – 2014 Audit Finding 10:[1] "The department does not calculate a recidivism rate and does not measure the effectiveness of custodial and non-custodial services provided to youth who have been adjudicated delinquent"

The audit recommended that the department define, calculate, publish, and periodically update a custodial recidivism rate. In addition, the department should develop other effectiveness measures for youth who have been adjudicated delinquent and placed in state

[1] Follow-up on 2014 Finding 9 is combined with follow-up on 2014 Finding 12 and can be found on page 33.

custody. Lastly, measures should be established to monitor the effectiveness of the probation and aftercare programs.

The department has defined and is now calculating, publishing, and updating a custodial recidivism rate. The department has also developed other effectiveness measures for youth who have been adjudicated delinquent and placed in the department's custody.

The department has not yet fully implemented monitoring and usage of this recidivism information. For example, Senate Bill 2584, which the General Assembly ultimately passed on and which was signed by the Governor in April 2016, requires the department to report several pieces of data that will be useful to monitor the effectiveness of these programs. However, the first required report is not due until January 31, 2017, so the reporting is still under development.

The 2014 finding is partially resolved.

Follow-up – 2014 Audit Finding 11: "The department has not yet ensured full compliance with the 'evidence-based' law, and implementation has been inconsistent"

The audit recommended the department work with all contracted private providers to continue implementation of the evidence-based law and that the department ensures 100% of the funds expended for delinquent juveniles meet the statutory requirements.

The department is working with contracted private providers to continue implementation of the evidence-based law. For example, new Requests for Proposals include the requirement that vendors verify the use of evidenced-based programming throughout their array of services.

However, the department reports that some contractor- and department-provided services do not meet evidence-based requirements, and further analysis is needed at the service level to determine if the quantity and quality of these interventions are effective. The department is working toward developing information needed to address this problem. For example, to determine how well non-proven programs match research about the effectiveness of that particular type of intervention for reducing recidivism, the department is partnering with Vanderbilt Peabody Research Institute researchers to implement the Standardized Program Evaluation Protocol, a validated, data-driven rating scheme implemented in a number of jurisdictions including North Carolina, Arizona, Connecticut, Florida, Pennsylvania, and Tennessee. The department anticipates full implementation in the beginning of fiscal year 2018.

The 2014 finding is partially resolved.

CURRENT AUDIT RESULTS

Observation 1

The department took substantial actions to address security incidents

In recent years, the Department of Children's Services' Youth Development Centers (YDCs) experienced several highly published security issues, including riots and juvenile escapes. The department took significant action to respond to these problems. For example, the department reviewed each incident to identify and address specific weaknesses, such as adding bars to vulnerable windows. The department also placed some juveniles out of state in facilities better equipped to meet their needs. Since the publicized incidents, two YDCs have passed a program-focused accreditation process, with the third in process as of September 2016.

The department is also in the process of implementing a behavioral tool intended to provide more therapeutic support for juveniles. A traditional correctional model is based on reward and punishment, where privileges are removed for bad behavior, often in a strict fashion. However, under a therapeutic model, privileges are earned. Additionally, juveniles who slip into an inappropriate behavior are not necessarily immediately and severely punished. Rather, the staff focuses on working with juveniles to learn from the mistakes as teaching and learning opportunities.

Incident Reporting Mechanism Allows Management Analysis

Given the inherent high risk of dangerous situations and the recent history of such situations arising in YDCs, it is critical that the department's incident reporting process be robust and reliable in order to allow the department to quickly identify problems and trends, enabling rapid, proactive management. Department policy requires YDCs to report incidents in the Tennessee Family and Child Tracking System (TFACTS) within a specified timeframe. YDCs are required to enter incidents identified as significant within 24 hours while insignificant incidents are to be recorded within two business days. The department has identified a number of incident types that qualify as significant (see Appendix 4 on page 61 for examples of significant incident types).

The number and type of each incident are reported by the YDCs to the central office which tracks incidents to identify trends and the need for possible implementation of corrective action plans. The number and type of incidents reported for each YDC for the fiscal year 2015-2016 are shown in Appendix 4 (see page 61).

Finding 1

Incident reporting needs to be more timely

To assess whether the department's incident reporting data as presented in Appendix 4 (page 61) is reliable, the auditors tested the department's incident reporting process. We found that the department did not consistently adhere to policy time guidelines when entering incidents into TFACTS.

Auditors reviewed a sample of YDC working days to determine whether all incident reports were included in the statewide data and whether they had been reported in a timely manner as required by the June 2014 policy. Specifically, auditors randomly selected three working days between January 1, 2015, and June 30, 2016, and reviewed all incident reports generated for each of those days at each of the three YDCs. We found that 80% of the incident reports were not submitted in a timely manner. Table 1 details testwork results.

Table 1
Department of Children's Services
Testwork Results on Timeliness of Incident Reporting
For a Sample of Working Days Between January 1, 2015, and July 1, 2016

Type of Incident	Incidents Reviewed	Incidents Not Meeting Reporting Requirement	Percentage Not Meeting Reporting Requirement
Significant	10	10	100%
Insignificant	13	9	69%
Total	23	19	83%

Department management reports that while YDC staff was expected to follow the policy during the time period audited, experience has shown that it takes time for department staff to learn and implement the policy. However, the timeliness policy tested went into effect in June 2014. Even with some unofficial grace period while staff mastered the process, enough time had elapsed to expect adherence.

Recommendation

The department should ensure YDC staff report incidents within the timeline established in department policy. Additionally, if training and informal grace periods are deemed necessary in the future due to policy changes, the department should ensure these informal grace periods are reasonable.

Management's Comment

We concur in part.

The current policy, 1.4 Incident Reporting, was revised in 2014 to assure that all reviews met the criteria for COA compliance. Enhancements were made to TFACTS to incorporate the policy changes and training was provided to all private providers and DCS staff responsible for entering incidents into the system. While there were issues with timely entry of incident reports, at no time was the safety of youth or staff at risk due to the delay in entering the reports into TFACTS.

Once incident information is gathered it must be assessed for consistency and accuracy. The following documents must be in an Incident Report packet prior to entering an Incident Report in the TFACTS system:

1. End of Shift Report
2. Parent Notification
3. Discipline Report
4. Accident/Injury Report
5. Facility Incident Report, and
6. Student Seclusion Placement

All of the above mentioned steps are completed within 24 hours of the incident. Significant incidents are reported to Central Office via the End of Shift Report. The timeliness breakdown occurs in entering the information into the TFACTS system. This delay in entering the data into TFACTS does not impact the youths' safety due to the other processes in place, including supervisor review of the incident prior to end of shift, supervisor documentation of all incidents on the end of shift report, and Central Office daily review of the end of shift report. Significant incidents at YDCs such as abduction, major events at the facility, runaway/escape, death, serious injury, allegations of sexual abuse, or any incident that involves a youth going off campus for medical treatment are immediately reported to the Superintendent, the Director of Residential Operations, and the Deputy Commissioner of Juvenile Justice who in turn notifies the Commissioner and any other relevant parties.

In the incidents sampled at Woodland Hills and Mountain View the entering of the incident was delayed by an average of 3 business days but internal reviews were conducted in compliance with the COA requirement of an internal review within 24 hours.

The incidents sampled at Wilder YDC occurred during a time when the staff person responsible for entering incidents was absent on extended leave. Due to staffing shortages no one was assigned to enter the finalized incident reports. This lapse in entry was identified by quality control processes and the situation was corrected. However, it is important to note that ALL incidents during that time frame were properly reviewed within the 24 hour timeframe and when warranted, appropriate action was taken.

The Department has identified actions that can be put in place to address data entry timeliness. All YDCs will assign one person per shift to gather and review the documents required for the incident reporting packets to ensure accuracy of information. Increased training and mentoring will occur to improve timeliness and accuracy of the information. It should be noted that while new employees receive training on how to write Incident/Facility reports this is a skill that requires coaching and mentoring to develop quality documents. Further, to address the issue of volume of incidents the Department will ensure that adequate personnel resources are on-site to enter the data into TFACTS. Gateway to Independence and Mountain View will have one trained person primarily responsible for data entry and one assigned back-up person. Wilder, based on the volume, will have two trained personnel primarily responsible for data entry and one additional back-up person. Central Office will monitor the timeliness of data entry via reports from Oracle Business Intelligence Enterprise Edition (OBIEE) and review the results with management teams at each facility. The Department has been meeting with internal stakeholders during the State Fiscal Year 2016 to streamline and update policy 1.4 Incident Reporting and its associated work aids and manuals. The updates will take into consideration changes in practice and procedures, which will include and are not limited to, timeframes in data entry.

CHILD SAFETY and PROGRAMS

Hotline Call Steps and Outcomes

The Office of Child Safety, Child Protective Services division, is responsible for receiving and investigating allegations of child abuse and neglect. When someone reports suspected child abuse or neglect to the Child Abuse Hotline, case managers gather pertinent information about the allegation, identify any department history with the family, and enter the information into the Tennessee Family and Child Tracking System (TFACTS). Case managers utilize the Structured Decision Making (SDM) tool within TFACTS to answer a series of yes/no questions for each allegation to make a screening decision and assign a track. Allegations that do not meet the statutory requirements are either referred to resource linkage which can help the family find help in the community or screened out by the hotline case manager, subject to supervisory review. Allegations that meet the criteria for abuse or neglect are assigned to one of the following tracks:

- Assessment – The approach seeks to understand the underlying conditions and factors that could jeopardize a child's safety. The focus is holistic and involves a formal assessment of the child's safety. The department's Assessment Unit and the family work together to gather information and develop a workable plan to ensure the child's safety.
- Investigation – For all reports of severe neglect or abuse, a traditional investigation takes place. Law enforcement may be asked to assist in these cases. In this approach, the department's Investigations Unit focuses on finding out what caused the incident to be reported, and it seeks to find out who was responsible and what steps need to be taken to ensure the child's safety.

TFACTS also assigns a priority level, which dictates how quickly the field assessment/investigation case worker must respond to the call:

- Priority-1 (P-1): Reports that allege children may be in imminent danger.
- Priority-2 (P-2): Reports that allege injuries or risk of injuries that are not imminent, life threatening, or do not require immediate medical care.
- Priority-3 (P-3): Reports that allege situations/incidents considered posing a low risk of harm to the child.

The hotline case manager also has the ability to override TFACTS' track and priority assignment when appropriate. All of these decisions are subject to supervisory review. After a priority is set, the hotline case manager makes a final determination, and then the report is referred to the appropriate field supervisor in TFACTS. At this time, the intake becomes an open case.

In fiscal year 2014-2015, DCS reported the hotline handled 140,199 calls and 9,233 website referrals. Of these reports, DCS stated 69,868 referrals were assigned for investigation or assessment, with 32,983 assigned to investigations and 36,885 cases assigned to assessment.

Case managers screened out 40,095 reports and referred 441 to resources. (See Table 2 below.)

Table 2
Department of Children's Services
FY 2014-2015 Child Abuse and Neglect Report Data

CPS Assignments*	
Investigation	32,983
Assessment	36,885
Subtotal CPS Case Assignments	69,868 (46.8%)
Resource Linkages	
Referred for Resource Linkage*	441 (0.3%)
Screened-Outs	
Screened-Out**	40,095 (26.8%)
Other (Non-Intake) Hotline Calls**	
Out of State Courtesy Calls	12,609
Informational Calls	26,419
Subtotal Other Hotline Calls	39,029 (26.1%)
Total Hotline Transactions*	149,432

Sources:
* FY 2014-2015 DCS Annual Report.
** Additional information provided by DCS.

Child Protective Services investigators, under supervisor guidance and review, gather evidence, assess child safety, and determine whether allegations are substantiated or non-substantiated, meaning the department is making a formal decision whether or not the child abuse or neglect occurred. Typical investigative tasks include interviewing alleged child victims, witnesses, and families; performing home visits; and coordinating efforts, such as forensic medical exams, with law enforcement, juvenile courts, and child advocacy centers.

Severe Abuse and Child Protective Investigative Teams

In cases of severe abuse, Child Protective Investigative Teams (CPITs) are convened to provide a multi-disciplinary approach to investigations. CPITs provide support to the child victims and their families while working together during an investigation to determine, through an evaluation of evidence, whether the severe abuse allegations are substantiated. Required CPIT team members include representatives from the department, the District Attorney General, a juvenile court officer or investigator, law enforcement officials, and the director of the local Child Advocacy Center (CAC).

Once the department decides whether the abuse is considered substantiated, the department also decides whether the alleged perpetrator should be found responsible for the child's condition. After classification determinations are made, case managers then close the case or refer it to a family caseworker for ongoing services pending administrative review.

PRIOR AUDIT FINDINGS

Follow-up – 2014 Audit Finding 1: "The department can improve investigation thoroughness"

The audit recommended the department should ensure that all investigations are consistently and thoroughly conducted and documented and are subject to supervisory review in TFACTS, with paper storage reserved for only those isolated types of documentation that are currently problematic for TFACTS. The department should also continue to identify and address such TFACTS problems and, as they are resolved, ensure case managers are notified that all future documentation should be maintained in TFACTS. Finally, results of internal case file reviews should be aggregated, tracked, and analyzed to identify recurring and current investigations. This information should be used to improve training and policy and procedure updates.

As further discussed in current audit Finding 2 (page 20), we found while some child safety investigations appear to have been conducted thoroughly, others were missing key documentation and may not have been as thorough as possible. In addition, it appears that not all investigations were classified and/or closed in a timely manner. Since cases of abuse can have severe consequences for families involved, it is critical that Child Protective Services cases are thoroughly investigated, documented, and completed in a timely manner.

The 2014 finding is partially resolved.

Follow-up – 2014 Audit Finding 2: "The department can improve some Child Protective Investigative Teams' operations"

The audit recommended the department require that all Child Protective Investigative Teams (CPITs) act in a consistent and effective manner, including ensuring invitations are sent to all required parties and that all caseworkers bring cases to the CPITs during the active investigative stage. Additionally, CPITs coordinated by department personnel should conduct

the same self-evaluation as CPITs operated by outside organizations, such as Child Advocacy Centers (CACs).

The audit further recommended that the department improve its communications with CPITs by addressing technical issues with its system's ability to communicate with CACs and ensuring CPITs are notified and updated on all cases initially assessed as requiring a CAC.

The 2014 finding is partially resolved. Additional details are provided in current audit Finding 3 (page 26).

Follow-up – 2014 Audit Finding 3: "The department needs to better track child abuse and neglect referrals faxed in to the Child Abuse Hotline"

The audit recommended that the department improve its tracking of child abuse and neglect referrals received by Internet, fax, and mail through such mechanisms as better hotline staff training or performing reconciliations between its manual log tracking these referrals and TFACTS.

The department has improved how it handles referrals received by Internet, fax, and mail in the following ways:

- Internet reports are now tied directly into TFACTS. As the reporter enters the information via the department's Internet reporting page, a TFACTS report is created. The department reports receiving 12,559 Internet reports in 2015.
- Faxed reports are received through a central service desk. Staff are assigned to log and store these faxes, and hotline case managers are assigned to enter the faxed information into TFACTS. The department reports receiving 2,416 faxed reports in 2015.
- Emails are directly entered into TFACTS via automation. This has been in effect for over a year, and the department reports receiving 365 email reports in 2015.

The 2014 finding is resolved.

Additional information about hotline operations is located in current audit Observation 2 (page 27).

Follow-up – 2014 Audit Finding 4: "The department has not complied with all legislative reporting requirements"

The audit identified that the department had not complied with state statute regarding seven of its numerous mandated reporting requirements. These multifaceted statutory reporting requirements include statistics and efforts to address various aspects of child safety. The audit provided detailed recommendations to bring the department into compliance.

Department and legislative staff report conducting an in-depth review of the department's relevant statutes and identifying all of its reporting requirements. The department also developed a new robust function with dedicated staff within its Central Office to track the department's compliance with reporting requirements, including whether the reports contain the required elements.

The 2014 finding is resolved.

CURRENT AUDIT RESULTS

Finding 2

A significant number of investigation files were missing key documentation required by department policy, which opens the possibility that the investigations might not have been completed thoroughly or as timely as possible

While the majority of child safety investigations were thorough, others were missing key documentation and may not have been as thorough as possible or resolved in a timely manner. Since cases of abuse can have severe consequences for families involved, it is critical that Child Protective Services cases are thoroughly investigated, documented, and completed in a timely manner. The department is using its quality review process to help identify and mitigate these problems.

To determine whether cases were thoroughly investigated, documented, and completed in a timely manner, we

- interviewed central and regional management;
- reviewed relevant DCS policies, procedures, work aids, and internal quality improvement tools; and
- performed a file review of 60 Priority-1 investigation case files from three regions across the state.

We observed electronic and paper documentation for a randomly selected sample of 60 Priority-1 investigations opened from August 1, 2015 to January 31, 2016, from three judgmentally selected regions across the state—Southwest, Tennessee Valley, and Mid-Cumberland. The three regions were selected to include cases from both urban and rural counties in each of the State's Grand Divisions.

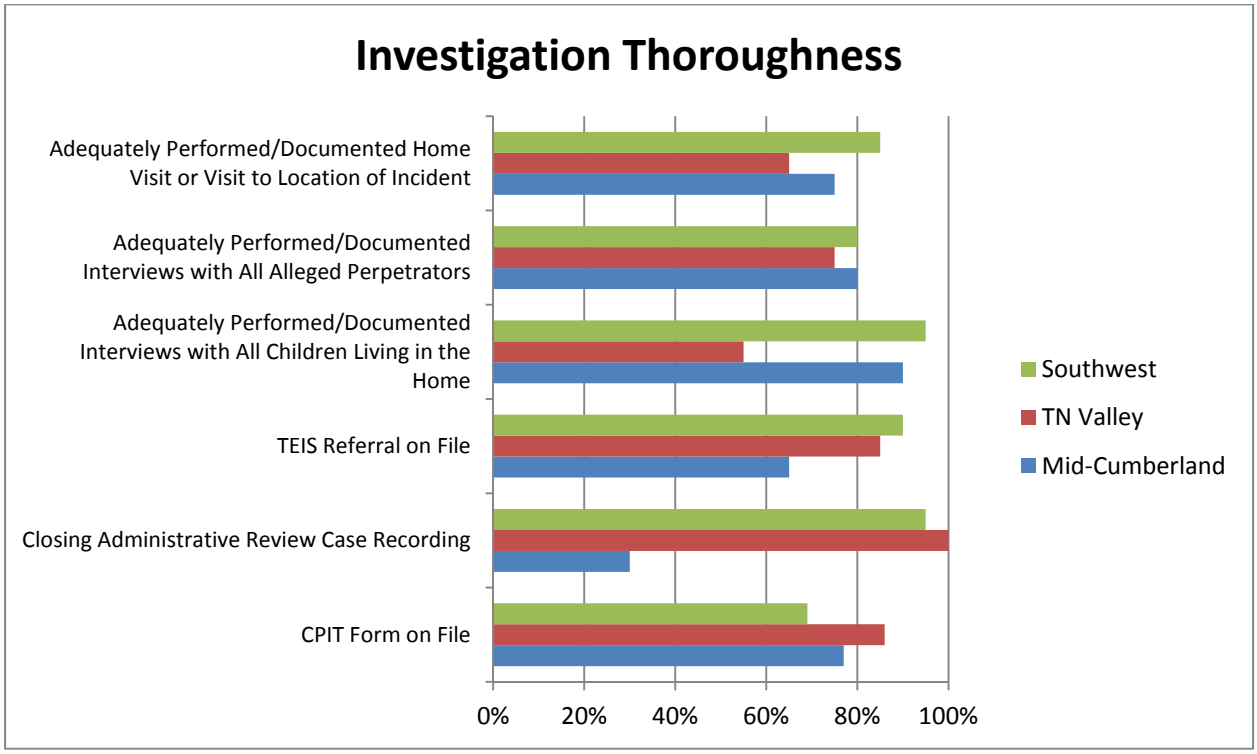
Investigations Not Always Appropriately Documented, Thorough, or Supervised

The quality and quantity of case documentation and the thoroughness of the investigation are very closely related concepts. Without quality documentation, it is difficult to determine whether a thorough investigation was conducted. Insufficient investigations can lead to negative

child outcomes if critical information is not available when courts and the department make critical decisions about a child's safety.

In our file review, we found investigation files missing key documentation required by department policy, which opens the possibility that they might not have been completed thoroughly. It is possible that the step was completed but simply not documented. Chart 1 below summarizes some of the results of our review for each of the three regions.

Chart 1
Department of Children's Services
Investigative File Review Audit Results



Source: Auditor's file review of randomly selected sample of 60 Priority-1 investigations opened from August 1, 2015 to January 31, 2016, from three judgmentally selected regions across the state, Southwest, Tennessee Valley, and Mid-Cumberland.

Of the 60 cases reviewed, we identified the following:

- **Twenty-four percent of reviewed files involving severe abuse lacked key, mandated CPIT meeting documentation.** Specifically, these files were missing a completed and signed CPIT meeting form no. CS-0561. This form is required by Department Policy 14.6 for all severe abuse cases. These forms are important because they demonstrate that the child's situation was examined from a variety of perspectives, including legal, medical, and psychological. The form also notes any classification disagreements among CPIT members.

- **Twenty percent of files reviewed lacked documentation of interviews of all children living in the home, as required by department procedures.** In the Tennessee Valley Region, 45% of files lacked the appropriate documentation that these interviews took place. In comparison, less than 10% of reviewed files from the other two regions lacked evidence of these interviews.

- **Twenty-two percent of cases reviewed lacked detailed documentation of interviews with all alleged perpetrators.** Specifically, these cases lacked detailed documentation that either the department investigator or other CPIT members, such as law enforcement, conducted such interviews. For example, in one case reviewed, one of the alleged perpetrators, who was not a relative or caregiver of the alleged child victims, was substantiated for drug-exposed child abuse against two of the alleged child victims. An interview with this alleged perpetrator was not noted in the case file. Additionally, other key documentation was missing from the file such as CPIT documentation.

- **Twenty-five percent of reviewed files did not contain documentation that a required home visit occurred.** These home visits are important for the caseworker to observe the child's overall home environment, including all areas related to the allegations and conditions that appear to pose a risk to the child's safety.

Many files lacked documentation that adequate closing supervisory review had occurred. Department Policy 4.4 requires each investigation to have a documented administrative review by a supervisor before a case is transferred or closed. Supervisory reviews can help ensure that cases have been adequately investigated and are ready for closure. While supervisors could be conducting adequate supervisory review through mechanisms other than this particular review documentation, the lack of documentation is a key indicator.

Overall, 75% of reviewed files included documentation that supervisors had conducted closing administrative reviews. However, one region, Mid-Cumberland, was responsible for a significant portion of these administrative review omissions. Only 30% of the Mid-Cumberland files had a documented closing administrative review by a supervisor. In comparison, over 95% of other regions' reviewed files contained appropriate documentation of this review.

A Significant Number of Investigations Did Not Meet Key Benchmarks

Our file review also revealed that investigative timelines were not always met:

- **Structured Decision Making Safety Assessments** were not completed within the required 72 hours of initial contact with the child and family in 33% of reviewed files. These assessments help determine whether a child is safe in the current environment and are critical to swiftly addressing any safety concerns.

- **Classifications** were sometimes not completed in a timely manner, especially for non-severe abuse allegations. Department policy generally requires investigations of non-severe abuse to be classified as either substantiated or unsubstantiated within 30

days after the department's receipt of the initial allegations, with a few very specific exceptions. Overall, these classifications were not made within the 30-day limit in 48% of reviewed files involving non-severe abuse allegations. However, classification timeliness differed greatly between regions. For example, only 31% of the reviewed files were classified within 30 days in the Tennessee Valley Region, while 86% of reviewed files were classified within 30 days in the Mid-Cumberland Region.

In comparison, department policy requires investigations of severe abuse or other specified rare circumstances to be classified as either substantiated or unsubstantiated within 60 days after the department's receipt of the initial allegations. These classifications were not made within the 60-day limit in 15% of reviewed files involving severe abuse allegations, with no major variations noted between tested regions.

- **Case closures** did not occur within required time frames in 57% of reviewed files. Specifically, department policy dictates that investigations be closed within 60 days with a decision to close the case, provide services, refer to community providers for ongoing services, or transition to ongoing services at the time of closure.

Due to the nature of child safety investigations, such delays have the potential to slow the provision of services to children and the identification of perpetrators.

Newly Developed Quality Reviews Have the Potential to Help Identify and Address Problems

To monitor and help lessen the potential for incomplete, insufficient, or untimely investigations, in 2015 the department developed a peer review quality review process for investigations. Because this process is new, it has not yet had an opportunity to effect wide-scale investigative improvement. The first set of statewide peer reviews were completed in the second quarter of 2015 and the first round of quality improvement plans were completed in the first quarter of 2016. These reviews found several potential problems similar to the problems identified in this audit, suggesting there may be meaningful results going forward. For example, the initial reviews identified concerns with sibling interviews, classification timeliness, administrative reviews, safety assessments, and investigation closure timeliness.

Recommendation

The department should ensure that all investigations are consistently and thoroughly conducted, documented, and reviewed, with key investigative time limits met. As a part of this effort, the department should continue to perform investigation quality reviews, as well as develop and implement quality improvement plans based on the review results.

Management's Comment

We concur.

This response will address prior audit findings (2014) as well as current findings. (Page 18, Follow-up – 2014 Audit Finding 1; page 20, Current Audit Finding 2)

The Office of Child Safety (OCS) fully implemented the Quality Review Process statewide in December 2015. This comprehensive review identifies areas of improvement to enhance the quality of investigations. Through the Continuous Quality Improvement (CQI) process, Quality Improvement Plans are developed and implemented when areas of improvement are identified through the quality review. The CQI process was rolled out statewide in September 2016. On the state level, the data has been used to inform training, policy or practice changes.

OCS recognized the need for improvement in the area of documentation of interviews of all children living in the home and the alleged perpetrators. As a result, Quality Improvement Plans are established to address the documentation of the interviews. The process has assisted in improving the quality. Additionally, further enhancements of the Quality Review Process are being piloted to conduct cross regional peer reviews to provide an external form of feedback to promote uniformity across the state.

The Office of Child Safety also recognized the need for efficiency in investigations and in December 2015, the unit began the process of transitioning files from paper to electronic. Through this process, the CPIT meeting form CS-0516 will be uploaded into the TFACTs system. There are CPIT teams that complete the form during the meeting and then hold the form for logging into the Child Advocacy Center database (NCATrak) prior to sending the final copy to the local DCS worker. Uploading the form electronically will reduce the administrative burden of securing the closed case upon receipt of the signed CPIT form.

During the timeframe of the selected sample of cases, the department was transitioning the FAST 2.0 tool from an outside database (Redcap) into TFACTS. Two indicators on the FAST 2.0 specifically address the home environment (home maintenance and physical condition of the home). Both of these indicators are in the safety assessment portion of the FAST 2.0 that is completed in the first 72 hours from contact with the child. Additionally, SafeMeasures has been rolled out and the FAST 2.0 is being measured in the database to track compliance of these assessment tools down to the worker level. This system will alert the worker of upcoming work to ensure that the tasks are being completed timely.

Administrative reviews by supervisors were identified as a driving indicator of quality work. OCS is currently piloting a process using pre-existing fields in TFACTS for supervisors to document administrative reviews at key points during the investigation.

Key Benchmarks:

The Structured Decision Making safety assessment was phased out from August 2015 to November 2015 and was incorporated into the existing FAST 2.0. To further support timely

completion of the tool, compliance reports through the SafeMeasures program were created. The program includes a worker dashboard and displays alerts of upcoming work to ensure timely submission.

In addition, SafeMeasures assists with the timeliness of classification and closure submission. Within the program, there are classification and closure reports to alert staff of upcoming work. Workers have a dashboard that provides ease of tracking this work. This also allows supervisors to easily monitor individual workers completion of investigative tasks. OCS has implemented a supervision plan to assist leadership in closely monitoring investigative tasks. The plan reduces the number of staff to no more than four to five workers assigned to a supervisor in an effort to assist regions in further enhancing excellence in investigations. A core function of supervision is to assess worker knowledge, skills, and abilities against the mission, values, and practice standards of the agency, with the goal of strengthening worker performance. This includes assessing what additional training, coaching, and mentoring is needed to help workers set and achieve job outcomes.

The supervision pilot was implemented to reduce the number of staff assigned to a supervisor and determine if this would improve the quality of the work in investigation cases across the state.

The results have shown:

- Increased time for supervisors to manage, lead and coach their staff
- Improved quality in casework and documentation
- Improvement in team morale
- Improvement in building community relationships
- Increased time for supervisors to focus on the purpose, goals and mission of the Department

The plan was piloted in 2015 with three regions and the statewide rollout remains ongoing.

Through coordination with the CPIT team on severe abuse cases, there are allegations that are not appropriate to classify at day 30. The department works with community partners to ensure that the team has the appropriate evidence to make an informed decision prior to closure. The 60 day timeframe is utilized not only for investigative purposes, but to also implement services to ensure child safety. Investigative staff may delay closure to evaluate whether or not further departmental or court involvement is required for service provision to ensure ongoing child safety.

Finding 3

A Child Protective Investigative Team Advisory Board has been formed, but the board has not developed statewide protocols

In order to help develop standards and take other steps to make Child Protective Investigative Teams (CPITs) work more consistently and effectively across the state, the department created the CPIT Advisory Board in 2014. However, the board has not yet developed statewide protocols needed to help ensure CPIT effectiveness and consistency.

CPITs are statutorily defined multi-disciplinary teams composed of key members in the community who work together to aid the investigation of severe child abuse to ensure child safety and support. Section 37-1-607, *Tennessee Code Annotated*, indicates that teams will be composed of the following:

- one (1) person from the department;
- one (1) representative from the office of the district attorney general;
- one (1) juvenile court officer or investigator from the court of competent jurisdiction;
- one (1) properly trained law enforcement officer with countywide jurisdiction from the county where the child resides or where the alleged offense occurred; and
- a Child Advocacy Center (CAC) director, or a designee, in areas where a CAC is located.

An additional member may be included from the mental health discipline. Statute further requires the creation of a CPIT team for each county.

According to its charter, the board's purpose is to "provide guidance and consultation on practice and protocol standardization to CPITs across Tennessee." The charter also calls for the board to meet no less than once per quarter. For 2015, the board's membership included 36 members, plus 3 vacancies.

As of June 2016, the board has not established standardized statewide protocols. Additionally, there is little documentation to demonstrate that significant progress has been made since the initial 2014 meeting. The board met only two times in 2015 and attendance has been low at board meetings. Its December 2015 meeting was cancelled due to lack of attendance. From April 2014 to June 2016, for meetings in which attendance was noted in the minutes, on average only 14 members (39%) attended. The majority of those in attendance were from CPS and CACs.

Recommendation

The department should develop standardized CPIT protocols using either the CPIT Advisory Board or another mechanism. The Advisory Board, whether used or not, should meet more frequently with fuller attendance.

Management's Comment

We concur. (Follow-up to 2014 Audit Finding 2 – The 2014 finding is partially resolved and Finding 3 – A Child Protective Advisory Board has been formed, but the committee has not developed statewide protocols)

The Child Protective Advisory Board has not yet created a standardized statewide protocol due to the need to address other urgent and pressing issues that arose within the CPITs across the state. However, a plan has already been put into place to create the protocol. There has been much progress by the Board, even if the meeting minutes do not reflect the progress that has been made. Some of the urgent issues that were addressed by the Board include: the timing and frequency of forensic interviews being completed, the frequency of forensic medical exams being completed, the lack of a system to track prosecution outcomes of CPIT cases; legal issues surrounding the forensic interview statute regarding the "qualification" of interviewers; the legal issue of custody and maintenance of video recordings of forensic interviews; access to CACs by non-investigator DCS employees; substantiations of minors for child sexual abuse; a CPIT presentation tool used by CPS supervisors to review the quality of CPIT case review presentations by CPS investigators; and CPIT partner concerns of the Department's use of AWS in the field.

In 2017, the Department anticipates increasing membership attendance and developing a statewide CPIT protocol through the use of the new "committee" meeting format. In addition, the Department anticipates that the Board will continue to address both new and ongoing issues through the use of the committees and through the Board as a whole. It is anticipated that quarterly meetings will still occur as scheduled, but Board members will also meet, via in-person meetings, email discussions, or telephone conference calls, with their respective committees in addition to the quarterly meetings.

Observation 2

The Child Abuse Hotline refers most reports to the local investigative unit in a timely manner, but lacks some tools that would be helpful to analyze the process

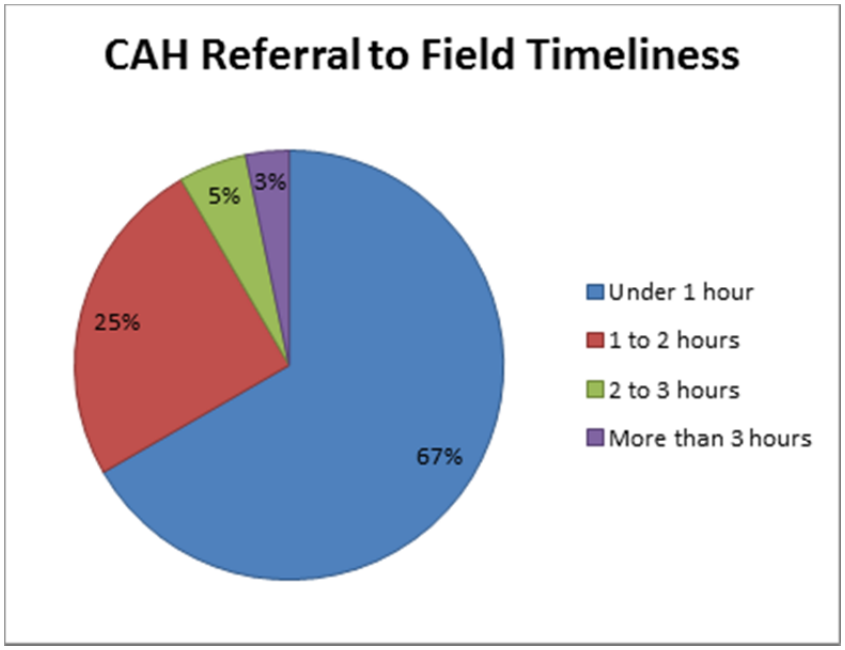
The Child Abuse Hotline receives, categorizes, prioritizes, and refers allegations of child abuse and neglect to the field for investigation. According to departmental policy, hotline case managers have 24 hours to determine whether information reported meets the criteria for abuse and/or neglect. The hotline utilizes Cisco brand call management software to track information

about each call and the Tennessee Family and Child Tracking System (TFACTS) to process and track intakes.

Reports Referred in a Timely Manner

Based on an analysis of TFACTS data for the 4,914 Priority-1 cases received between August 2015 and January 2016, the hotline refers the majority of Priority-1 cases within 24 hours. On average, almost 67% of calls were referred within one hour and only approximately 3% were referred in more than 3 hours. (See Chart 2 below for additional details.)

Chart 2
Department of Children's Services
Priority-1 Reports Received Between August 2015 and January 2016



Source: Auditor Analysis of TFACTS raw intake data for Priority-1 reports received between August 2015 and January 2016.

Lack of Call Center and TFACTS Communications Hindered Analysis

While the hotline staff refers complaints to the field in a timely manner, the department has no mechanism to analyze the complete time it takes between when a call is received and when it is referred to the field. This is important for a variety of reasons. For example, reports of children in immediate jeopardy need to be handled as quickly as possible. Detailed analysis of the call process, combined with TFACTS data, is needed to understand if there are opportunities to further improve timeliness.

Although the Cisco call center system collected the date and time, duration, and hold time of each call, call center management did not have a way to link this call data with an intake in TFACTS. When a call came in to the hotline, the Cisco call system recorded the call history, as well as other information about how the call was handled by the case manager. The case manager who answered the phone gathered pertinent information from the referent and put that information into TFACTS. Once the case manager started typing a new intake into TFACTS, the system logged this moment as the intake date and time. Since the setup did not link Cisco call data to intake data in TFACTS, it is possible that there could be a gap between the time the call actually came in to the hotline and the time the case manager began entering information into TFACTS. Linking the Cisco call system data to an intake ensures that the whole process is trackable from start to finish, so that any possible delays in the process can be identified and addressed.

Policy Unclear on Timeliness

While the referral process appears timely under department policy, written department policies could be clarified to help case management staff and allow better analysis of call center and investigation timeliness. Department Policy 14.3 requires hotline staff to determine within 24 hours whether the reported information meets the criteria for abuse and/or neglect. However, the same policy also references Section 37-1-606, *Tennessee Code Annotated*, and requires Priority-1 cases to be initiated by a face-to-face contact with the alleged child victim no later than 24 hours, but immediately if the supervisor deems necessary. The policy does not clearly state whether the clock starts when the child abuse or neglect report comes in to the hotline or at the end of the intake process once a screening decision has been made.

Management expectations are that Priority-1 response time should be 24 hours from the end of the intake process. In part, this is necessary because data linking a TFACTS case to a specific call center call is not available. However, if both the call center and field investigators are given 24 hours, 48 hours could theoretically elapse before a department caseworker sees face-to-face a child in immediate danger. While we are not aware of any data suggesting this occured, the lack of clarity in department policy provides the possibility.

Recommendation

In order to capture the entire intake process from start to finish, management of the Child Abuse Hotline should evaluate whether it would be effective and cost-effective to link Cisco call data to intakes in TFACTS so that any possible delays in the process can be identified and addressed. Department policy should also be updated to clarify timeliness requirements for hotline case managers to refer cases to the field, and the time investigators have to respond to cases.

Management's Comment

We concur.

In order to capture the entire intake process from start to finish, management of the Child Abuse hotline should evaluate whether it would be effective and cost-effective to link Cisco call data to intakes in TFACTS so that any possible delays in the process can be identified and addressed. Department policy should also be updated to clarify timeliness requirements for hotline case managers to refer cases to the field, and the time investigators have to respond to cases.

The Office of Child Safety recognizes the potential benefit of linking existing Cisco call data to Intakes in TFACTS. Representatives from the Office of Child Safety will meet and collaborate with staff from the Office of Information Technology to conduct analysis to determine the feasibility, effectiveness and cost benefits of pursuing the incorporation of this functionality in TFACTS. In addition, the current business processes associated with capturing referrals of child abuse and neglect will also be evaluated to confirm that the implementation of such functionality would complement the current Child Abuse Hotline business processes.

Response time begins at the time the referral is entered into TFACTS by the Hotline. This is built into TFACTS and priority response reports use that time to determine whether or not response time is met. The Office of Child Safety will update Policy 14.3 to clarify time requirements for the Hotline to submit referrals to the field and CPS field staff to respond.

ADMINISTRATIVE FUNCTIONS

The 2014 sunset performance audit report identified several findings regarding administrative support functions which serve multiple units. Specifically, the prior audit discussed network adequacy, volunteer background checks, and the department's computerized system, the Tennessee Family and Child Tracking System (TFACTS).

PRIOR AUDIT FINDINGS

Follow-up – 2014 Audit Finding 5: "Although the department has made efforts to improve the Tennessee Family and Child Tracking System, additional changes are needed to ensure the system is fully functional"

The audit report includes numerous recommendations to improve TFACTS' reporting quality and data accuracy, search function, cumbersome nature, system speed, financial functionality, and maintenance of coding.

The 2014 finding is partially resolved. Detailed current audit work and results are located in current audit Finding 4 (page 34).

Follow-up – 2014 Audit Finding 6: "Some of the department's background check files lack sufficient documentation that required checks and supervisory reviews had been completed, raising questions about the appropriateness of approval of volunteers and resource homes providing services to children"

The audit recommended the department ensure that all required background check forms are completed, signed, and reviewed prior to approval. The department should review the existing poicy, revise it as necessary, and provide additional training to ensure all employees are aware of and following the policy and its requirements. Finally, the audit recommended that the department should perform periodic reviews of a sample of background check files to help ensure background checks are appropriately completed and documented.

To gauge whether these recommendations had been implemented, auditors focused on background check files for individuals volunteering to work with DCS offices, including Youth Development Centers. We interviewed the DCS Statewide Volunteer Coordinator, who has been in place since 2013, and reviewed various policies, procedures, and manuals. Our review revealed that a number of these pertinent documents have been updated and some have been newly implemented, which was previously recommended. We also obtained listings of all volunteers serving from July 1, 2015, through June 20, 2016, showing 450 volunteers serving throughout 12 Regional Offices, DCS central office, and three Youth Development Centers (Table 3, page 32).

Table 3
Department of Children's Services
Volunteers by Location
July 1, 2015 through June 1, 2016

Location	Number of Volunteers
Davidson Regional Office	26
East Regional Office	15
Knox Regional Office	26
Mid-Cumberland Regional Office	32
Northeast Regional Office	15
Northwest Regional Office	29
Shelby Regional Office	36
Smoky Mountain Regional Office	22
South Central Regional Office	14
Southwest Regional Office	12
Tennessee Valley Regional Office	22
Upper Cumberland Regional Office	31
DCS Central Office	3
Mountain View Youth Development Center*	65
Wilder Youth Development Center	13
Woodland Hills Youth Development Center*	89
Total	**450**

Source: Department of Children's Services.
*Volunteer programs at these facilities have been put on hold. Mountain View currently lacks a coordinator. Woodland Hills has a coordinator, but the coordinator has been assigned other duties since October 2015.

The *Volunteer Services Procedures Manual*, revised in May 2016, requires an annual internal audit of volunteer files to maintain compliance with both DCS and Council on Accreditation documentation requirements. The manual further stipulates the audit must contain a minimum of 25 files. Department management reports that file reviews are typically conducted in May, June, and July.

The department has used these internal audits to improve its volunteer background check documentation and monitoring. First, in response to its 2015 reviews, the department created and implemented a new checklist that must be completed to ensure all necessary steps have been taken and documented for each volunteer's background check. Subsequent internal quality monitoring reviews found a tremendous improvement in the content and timeliness of the background checks' files as a result.

Additionally, the department increased the number of files it reviews through its internal monitoring process. In 2015, internal audit only reviewed a sample of cases. However, the

department reports that it is currently auditing 100% of its background check files. During our interview, the DCS Statewide Volunteer Coordinator stated that for this cycle she is reviewing 100% of volunteer files to ensure the proper implementation and assess the effectiveness of the checklist.

The 2014 finding is resolved.

Follow-up – 2014 Audit Finding 7: "The department should reassess its policies and the documentation maintained in Adoption Assistance and Subsidized Permanent Guardianship files to ensure that the necessary information is required and is included in the files"

The audit recommended the department reassess the documentation it keeps regarding these files and consider performing periodic reviews.

The department has taken several steps to improve documentation. For example, DCS updated its policies on contents of files for both adoption assistance cases and subsidized permanent guardianship cases. Similarly, the department reports reinstuting a quarterly case review of records associated with subsidy eligibility and payment. Finally, the department is moving from maintaining hard-copy paper files to a paperless system using TFACTS, which should help improve recordkeeping consistency.

The 2014 finding is resolved.

Additionally, the following prior audit findings are addressed through current audit Observation 3 (page 39) related to service network management.

- Follow-up – 2014 Audit Finding 9: "The department needs more residential treatment options to meet the needs of children who have been adjudicated delinquent" – The audit recommended the department conduct a needs assessment and develop further network resources based on the assessment's results. The department should also address concerns with the performance-based contracting process.

- Follow-up – 2014 Audit Finding 12: "The department needs to further assess foster care placement needs and monitor private provider placement practices" – The audit recommended the department continue identifying additional treatment and placement resources needed for youth in foster care, as well as conduct a needs assessment. The department should also continue developing a mechanism to monitor private providers.

Both 2014 findings are resolved. However, this audit identifies additional steps needed to ensure the future of the department's network capacity and management in current audit Observation 3 (page 39).

CURRENT AUDIT RESULTS

Finding 4

The department has taken steps to improve TFACTS; however, the department still has not implemented remaining recommendations from the prior audit

In August 2010, the department implemented a new child welfare system called the Tennessee Family and Child Tracking System (TFACTS). Since the system's conception, users have reported various issues with the system. In 2014, we reviewed TFACTS and determined that the department needed to improve upon seven areas related to the system.

- TFACTS' reporting capabilities and report data reliability,
- users' ability to search for information in TFACTS,
- TFACTS' cumbersome functionalities,
- TFACTS' slow speeds and unexpected logouts,
- TFACTS' financial functionality,
- in-house TFACTS training, and
- the department's ability to maintain TFACTS' OptimalJ codes.

For this audit, we interviewed program staff and observed the system to determine if the department has taken appropriate actions to address the issues found in the previous audit. We also surveyed 1,793 case managers, placement staff members, and juvenile justice case managers to obtain their opinions about the changes that have been made to the system. Of the 1,793 employees surveyed, 817 employees (46%) responded to the survey. Of those 817 who responded, 662 employees (37%) reported that they were employed by the department during the previous audit, suggesting they would be in the best position to comment on changes to the system. Therefore, we only used the responses from these 662 employees to determine if the changes have enabled the system to better assist them with their job responsibilities.

Based on our review, we found that the department made numerous changes to TFACTS to adequately address our recommendations and continues to make improvements to the system. However, users reported they still had difficulty using the system's search function and continued to experience slow speeds and logouts while using TFACTS. We also found that some of the financial functions in TFACTS were not operating correctly, so staff continued to conduct financial processes outside of the system.

Reporting Capabilities and Reliability Addressed, but the Majority of Workers Continue to Report Problems

The previous audit reported that staff questioned the validity of data in some TFACTS reports. In addition, staff reported that TFACTS did not generate some required reports, which resulted in staff keeping manual tracking documents outside of the system.

To address these concerns, the department implemented two new external reporting systems, Oracle Business Intelligence Enterprise Edition (OBIEE) and Safe Measures. These reporting systems allow staff to view real time statewide data in reports and through visual aids, such as graphs and charts. OBIEE is also used to provide data for the department's new reporting dashboard. The dashboard was created to improve upon the department's transparency by enabling the department to provide real time data about children in custody.

The information on the dashboard includes

- Adoptions Finalized,
- Children in Custody,
- Child Custody Trends,
- Parent Child Face to Face Visits,
- TFACTS Usage,
- Trial Home Visits, and
- Youth Development Center Population.

When we asked staff as a part of our survey, 54% of staff indicated they believe the reporting information is reliable.

Search Functions Expected to Improve With Added Technology

The previous audit reported that TFACTS' search function provided inaccurate search results and was difficult to use. In 2014, the department began conceptualizing the use of a new technology, called Solr, to improve the system's search function; however, it was never implemented. Our survey received numerous comments stating that search results still contain information that is not related to the search criteria. These inaccurate search results sometimes cause case managers to unknowingly create duplicate profiles in TFACTS for people already established in the system. These duplicate profiles make searching for individuals in TFACTS difficult and complicate search results even further.

The department reports that it is taking steps to implement Solr technology into TFACTS' search engine by fall 2016. Auditors viewed a prototype of the new search function and observed that it will have "sound like" capabilities so that staff can more easily find names in TFACTS. Also, the new search function will auto populate results as users type information into the search field.

Functionality Not As Cumbersome

In another effort to improve TFACTS, the department upgraded the system's user interface to make information easier to locate. In the previous audit, staff reported that TFACTS was difficult to navigate and staff had trouble locating critical information. Since the previous audit, the department made TFACTS less cumbersome by creating personalized homepages for

staff called "My Workpage," which allows case managers to view information about their assigned caseloads as well as a list of completed and uncompleted work tasks. In addition, it gives case managers the ability to view and edit their most recent case recordings on their homepage, instead of going through multiple screens. Supervisors can use their homepage to easily monitor case managers' work progress.

Staff Continue to Report Slow Speeds and Unexpected Logouts

The department has taken steps to improve TFACTS' speed and unexpected logouts by upgrading the entire TFACTS application and simplifying its infrastructure. Since the previous audit, the department upgraded the software and moved TFACTS to four higher capacity servers in a simpler, more efficient configuration.

The department reports that it continues to use DynaTrac software to proactively monitor TFACTS' performance; however, DynaTrac has been upgraded and is now working much better to identify performance issues in TFACTS. Although the department has improved its use of DynaTrac, it is also researching alternative programs to help identify technical glitches in the system.

Even though the department has taken steps to improve TFACTS' speed and reduce unexpected logouts, our survey concluded that only 37% of staff believe that TFACTS speed has improved since the time of the last audit. Therefore, the department may wish to continue to research additional programs that may better identify technical issues in the system and help to improve TFACTS speed.

Additionally, unexpected logouts continue to be a problem. Ninety-four percent of surveyed staff report experiencing unexpected logouts in TFACTS, resulting in loss of data. This may occur because TFACTS is programmed to log users out of the system if they are idle for a period of time. The department should consider extending the period of time before users are logged out of TFACTS to prevent case managers from losing information and having to re-enter information.

The department is also in the process of implementing an autosave function to enable TFACTS to periodically save information as it is entered.

OptimalJ Software Phasing Out

The 2014 audit reported that TFACTS was still being developed using the unsupported software, OptimalJ. We recommended that the department take steps to ensure that it could adequately maintain the TFACTS functions that were supported by OptimalJ.

The department reports that by the end of 2013, it was able to properly maintain all of TFACTS' OptimalJ codes in-house. However, the department subsequently decided to migrate away from OptimalJ. Beginning in January 2016, all new TFACTS projects were built using an Oracle based software rather than OptimalJ. The department anticipates that as new features are

added to TFACTS using the new software, older coding based on OptimalJ will slowly be replaced.

In-house TFACTS Training Enhanced

In the previous audit report and in a 2012 report, we determined that staff received insufficient TFACTS training when the system was first implemented. To improve TFACTS training, the department has since

- implemented a new TFACTS training curriculum consisting of a three-day training session that teaches staff how to complete common tasks, as well as tasks related to a trainee's specific job responsibilities;
- implemented a new electronic navigation manual, which provides detailed instructions for each TFACTS screen; and
- developed new TFACTS training methods, including remote learning with other employees across the state, computer training labs where employees can receive in-person hands-on TFACTS training, and "coaching sessions" in which trainers meet with staff one-on-one to provide personalized refresher courses for staff about how to navigate TFACTS.

Based on our survey, these efforts appear to be making progress. Seventy percent of respondents surveyed now believe they have received adequate TFACTS training.

Financial Reporting Remains Manual

We identified in the prior audit and 2012 report that TFACTS' financial functions were not operating correctly and department employees were using manual work-arounds to complete financial processes outside of the system.

TFACTS is still not operating correctly, and staff continue to perform manual work-arounds outside of the system. While the department reports that the manual work does not hinder employees from completing their work, it creates opportunities for human error in financial functions.

The department's Management Advisory Committee has approved a 13-phase project to automate all of the department's financial functions. However, the project has been delayed because resources were diverted to correct other areas in TFACTS. While it is important for the department to balance and prioritize its resources, financial functionality is critical to the state's financial integrity and accountability.

Recommendation

First, the department should continue its plans to improve TFACTS' search function by implementing the Solr technology or something similar. After implementation, the department should assess results, perhaps by obtaining feedback from frontline staff.

Second, the department should consider using additional troubleshooting programs to better identify technical issues in TFACTS, as well as extend the period of time before users are logged out of TFACTS due to inactivity.

Third, given the importance of accurate financial processing and reporting, the department should automate its financial functions through TFACTS.

Management's Comment

We concur.

Search Functions Expected to Improve With Added Technology

Solr is an open source enterprise search platform. This new, robust search functionality has been incorporated into the TFACTS testing environments, has been tested and is expected to be deployed in December 2016. Demonstrations of Solr search functionality have been conducted for Child Abuse Hotline staff and Regional Administrators and have been met with great enthusiasm. In addition, TFACTS Training staff has been engaged to incorporate this newly enhanced search capability into existing TFACTS Training curriculum. After full statewide deployment of Solr, the Office of Information Technology will certainly elicit feedback from frontline staff and will respond accordingly to further improve the user experience and reduce the potential of creating duplicate persons.

Staff Continue to Report Slow Speeds and Unexpected Logouts

The Office of Information Technology will certainly continue to research other performance monitoring tools to determine if other products may better address our needs as it relates to the identification and resolution of application performance issues and network traffic monitoring. In regard to unexpected logouts, currently the idle session timeout value for TFACTS Production is 3600 seconds (1 hour). This setting has been in place since October 2015. However, since DCS has been transitioning to a more mobile workforce, connectivity is often dependent on the type of device the worker is utilizing (PC, tablet, iPhone, tablet, etc.). The type of network connection the worker utilizes also plays a significant role in terms of connectivity and could be very much out of our control due to poor cellular service or a poor non-state Wi-Fi or broadband connection. In addition, in July 2016, an auto save feature was implemented in TFACTS where data is saved when the worker moves to a different field or navigates to another location within the screen.

Financial Reporting Remains Manual

The Office of Information Technology has initiated the first phase of thirteen phases to enhance TFACTS financial functionality, which will render any outside, manual, processes unnecessary. This first phase includes the enhancement to or development of functionality to support capturing client benefit accounts, a new accounts structure, check generation, refunds, historical funding adjustments, receipts generated from interface transactions, service structure, funding, funding mix, funding adjustments and Title IV-E Waiver. It is estimated that the first phase of this initiative will deployed in February 2017, with the remaining twelve phases to follow.

Observation 3

The department has made progress in addressing contracted foster care network adequacy, but due to the fluidity of the process, the department should take measures to ensure continuity

The Network Development Division uses a continuum model where custodial or adjudicated children stay with a single provider until they exit the system, no matter what level of care they need when first entering the department's care. This model focuses on the services required for each child, rather than solely physical placement.

There are currently three levels provided by private contractors:[2]

- Level 4 – subacute hospitalization;
- Level 3 – congregate care, where children are treated in a group setting; and
- Level 2 – residential group homes, some of which include schools within the group home.

(See Table 4 on page 40 for further information on placement types.)

The department has built in an incentive mechanism through performance-based contracting to move a child to the least restrictive situation as quickly as possible when appropriate. For example, if a child enters custody at Level 3, when the child subsequently moves to Level 2, the provider still receives the rate reimbursement at Level 3. Therefore, the faster the provider moves a child to a lower setting the higher profit they can attain.

The policy for child/youth referral and placement, which includes placement for custodial and adjudicated youth, was updated in April 2016 and more recently in August 2016. This policy stipulates that all placement decisions are made during the Child and Family Team Meeting (CFTM). The CFTM consists of a Family Service Worker, other department representatives, and

[2] Level 1 care consists only of department monitored foster homes.

specialized department experts who engage the family in discussing the unique needs of the child and family. The CFTM uses this information and assessment tools to identify the needs and level of placement required.

However, the CFTM does not determine the physical placement location. For example, the CFTM may determine a service need of Level 2, but a regional Placement Specialist reviews a list of providers and service array for each provider to determine both the availability and appropriateness of the physical placement. There are some special circumstances requiring involvement from other DCS staff or outside contractors. For example, any placement where a child has exhibited sexual behaviors requires review by doctors at the Centers of Excellence at the University of Tennessee. Additionally, placement of a child outside of the region in which the child was taken into custody or placement over 75 miles away requires approval from both Regional Administrators involved.

Table 4
Placement Options
From Least to Most Restrictive

Placement Type	Description/Comments
Within their own home	Whenever possible, the children/youth remain in their home with supportive services.
With relative or kin	This is preferred over a non-relative as long as the environment is safe and stable.
Foster Home - inside home county or neighborhood	Whenever possible, children/youth will be placed in a foster home within their home neighborhood or as close as possible.
Foster Home – outside home county or neighborhood	When foster homes are not available within their neighborhood, the children/youth are placed in a foster home near their home community.
Group Home	This placement is used when children/youth have moderate behavior problems that could not be better served in a family setting.
Residential Treatment Center	These facilities are used when children/youth have serious symptoms or major impairment in several areas such as work or school, family relations, judgement, thinking or mood, or a moderate to high risk of elopement.
Detention	The facilities are used as short-term placement only for delinquent children/youth who require constant supervision due to the risk to the community and/or others.
Youth Development Center	The centers are used for delinquent offenders who have multiple or aggravated felony offenses and pose a significant risk to the community.
Hospital/Sub-Acute	Hospitalization and similar settings are necessary when behaviors are influenced by delusions, hallucinations, or serious communication impairments.

Source: Auditor's analysis of Department Policy 16.46, "Child/Youth Referral and Placement."

The previous performance audit found that the department needed to further assess foster care placement needs and monitor placement practices of providers. It further observed additional capacity needs for adjudicated youth non-custodial services. The report recommended the department continue to identify and address additional placement and treatment resources needed for youth in foster care. To aid in this, the report recommended that the department conduct a formal needs assessment for each region and then work with private providers, advocacy groups, and community groups to determine how best to address identified needs. Finally, the report recommended that the department develop a monitoring program for providers who may be informally denying services to children for solely economic reasons.

Since the last audit, the department has reduced the number of contracted providers from approximately 80 to around 30. While this has made monitoring providers more manageable, it increases potential concerns regarding availability of services and the choices available. Additionally, the reduced number of providers combined with the continuum and performance-based contracting model, continues to raise the potential that providers could turn away children who are difficult to treat.

Non-Custodial Services Developed

To address the issue of non-custodial services for adjudicated youth noted in the prior audit, the department implemented the In Home Tennessee initiative to

- strengthen and improve in home services;
- develop an effective array of services; and
- engage children, youth, families, and community partners in service planning and delivery processes to achieve safety, permanence, and well-being.

Specifically, In Home Tennessee is a network of local resources to aid families served by the department. The department leverages a wide range of services throughout communities to address prevention for child abuse, drug abuse, and domestic violence; as well as mental health services, parent education, and therapeutic visitation. The department solicits help from volunteer organizations, research institutions, Community Advisory Boards, private providers, and other government agencies. Overall, this program provides not only a mechanism for prevention services but also a framework to aid youth and families once they exit custody, whether they were in foster care or detention settings.

Needs Assessment and Network Management Tightly Controlled

The department conducted a formal needs assessment beginning in March 2014 that was published on September 20, 2014. It considered placements for both custodial and adjudicated youth. The purpose was to examine current availability of residential and foster care placements in Tennessee; examine recent historical capacity; assess short-term anticipated changes in placement options; and determine how they align with long-term goals to bridge gaps in regional and state-wide services within the contracted provider network. This review also analyzed department placement data from July 1, 2013, through July 1, 2014.

The department concluded that although its analysis suggested there was sufficient capacity, it could still explore how the capacity is meeting the needs of children and youth and whether that leads to positive outcomes. The report specifically highlighted that many vacancies remained in homes. It also highlighted the demand for the highest levels of residential services (Levels 3 and 4) in the East and Middle Grand Divisions while the majority of Level 3 and 4 beds were located in the West Grand Division. The trend continues to be seen as of November 2015, although additional beds have been made available in Chattanooga and the state of Georgia. (See Appendix 5 starting on page 66 for provider location maps.)

Table 5
Residential Placements by Level of Care
For each Grand Division
Fiscal Years 2014 and 2015

Level of Care	Grand Division East		Middle		West		All Divisions	
	13-14	*14-15*	*13-14*	*14-15*	*13-14*	*14-15*	**13-14**	**14-15**
Level 1*	1,981	1,929	1,357	1,465	854	853	4,192	4,247
Level 2	856	834	664	623	344	346	1,864	1,803
Level 3	508	600	368	408	331	316	1,207	1,324
Level 4	64	75	59	57	23	27	146	159
Other	198	166	170	174	231	220	599	560
Total	3,607	3,604	2,618	2,727	1,783	1,762	8,008	8,093

*Level 1 consists of DCS managed foster homes, as opposed to foster homes managed by contractors. See explanations on page 39 for the other levels of care.

Source: Department 2013-2014 and 2014-2015 annual reports.

The department's longer-term network needs assessment is addressed through intensive utilization reviews. These reviews evaluate the necessity, appropriateness, quality, and intensity of individual client services to facilitate permanency and the most appropriate setting for service delivery as soon as possible. Reviews focus on the appropriateness and effectiveness of client services and reduction of length of stay in out-of-home care.

The department also contracts with Vanderbilt University's Center of Excellence for Children in State Custody to compile and analyze TFACTS data regarding placement location. The resulting reports enable DCS to more closely monitor the distance children are placed from their original commitment location, thus helping to identify localized service availability needs.

Indirect Service Denial Being Monitored

The department has a process in place to help monitor whether providers are failing to accept placement of some children with comparatively heavy service needs and/or difficult-to-manage behaviors. As discussed in the 2014 audit, providers may be reluctant to accept such

children because performance-based contracting provides financial incentives for timely, positive child outcomes. However, some children may require relative long-term treatment to achieve a positive outcome, which may be less certain than for other children with simpler treatment needs.

The department's placement exception request (PER) process was originally created to monitor compliance with parts of a class action lawsuit. However, the department has adapted this process to provide information beyond lawsuit compliance status, such as gauging whether providers are inappropriately turning away difficult-to-place children.

Department policy requires PERs to be completed when a variety of placement circumstances occur, including when children are placed outside of their home region and beyond a 75-mile radius, or when children reside in a primary treatment center for more than 30 days. While the criteria do not necessarily directly measure whether providers are inappropriately denying difficult-to-treat children, many of the circumstances requiring a PER may be more likely to occur when such denials are taking place. For example, if local providers are unwilling to accept children, it is more likely that the children may be placed out of their home region.

Each region is expected to complete a spreadsheet listing all PERs on a monthly basis. This process is completely manual as there are no fields in TFACTS to document the requests and, therefore, no reports are generated. Rather, individual case PER requests can only be manually uploaded into the TFACTS system for individual case management purposes. The department's Central Office staff summarizes the regional data, which is then used to identify issues requiring attention, such as an increase in placements away from the child's home region.

Because the PER data reporting and analysis process is manual, there is a potential for errors in determining when exception requests are required as well as when reporting full data to the central office. Incorporating PER information within TFACTS and automating the decision concerning when a request is required could mitigate human error while allowing for more robust reporting and analysis.

Performance-Based Contracting

The department also monitors its providers through performance-based contracts. The department adopted the performance-based contract approach, which provides financial incentives to contracts based on their achievement of child outcomes, in response to a class action lawsuit. The department contracted with Chapin Hall, a research and policy center at the University of Chicago, in 2006 to help develop overarching goals to use performance-based contracts. Chapin Hall also aids in the production and evaluation of baseline data, goals, objectives, and identification of review or reporting periods.

All contracts were renegotiated in 2006 to reflect the performance-based contract model. Specifically, these initial contracts required providers be measured against their own baseline attainment of goals related to the timely achievement of permanency including

- reducing the length of stay,

- meeting or exceeding targets on the number of exits from the system, and
- reducing the reentry of children into the system within 12 months.

The department offered a special financial incentive to providers who hit specified target measures the first year while not penalizing those contractors who did not meet their targets. However, full performance-based contracting, including the elimination of a grace period, was phased in over four years until fully implementation in 2009.

There were also some unintended consequences of performance-based contracting. For example, providers voiced concerns for the 2013 contracting cycle, which resulted in department changes to its performance-based model. Problems identified over time included the following:

- Payments to contractors varied greatly from year to year. In response, the department moved from a one year annual payment calculation to a three year window to smooth out such volatility.

- Difficulties in determining how to reimburse/penalize contractors which resulted in the implementation of a blended rate calculated by Chapin Hall.

- Concerns over the fairness of some providers measured against their own baseline, regardless of how well they may be performing in comparison to other providers. As a result, the department adopted a new baseline setting process based on multiple providers and 10 years' worth of data.

- Concerns about treatment of children with specific disorders. For example, additional considerations were added for specialized autism spectrum and juvenile delinquency services because these children progress relatively slowly through their treatment process.

Overall, the number of department contractors decreased from 80 private providers in 2006 to approximately 30 in 2016 under performance-based contracting. The department reports that this has resulted in an easier-to-manage network.

The department works to meet its clients' needs by direct day-to-day contact with most providers regarding daily census, client needs, and bed availability because all are in constant flux. The department's network managers attempt to balance bed availability on a day-to-day basis to avoid both large bottlenecks and slack. Maintaining an optimal mix provides only the minimum number of open beds needed to enhance efficiency. Therefore, because of the intense and coordinated nature of these activities, only a very few network management staff are involved. As a result, adequate succession planning is critical to ensure the continuity of institutional knowledge and a pool of trained staff able to continue operations on a day-to-day basis regardless of future personnel changes. Given the importance of day to day network management the department should have an adequate succession plan in place to ensure process continuity and the transfer of institutional knowledge.

SECOND LOOK COMMISSION

ORGANIZATION AND STATUTORY RESPONSIBILITIES

The Second Look Commission (SLC) was created in 2010 by Section 37-3-801, Tennessee Code Annotated, as an independent commission that reviews second or subsequent severe child abuse cases that are investigated by the Department of Children's Services (DCS). The SLC is administratively attached to the Tennessee Commission on Children and Youth (TCCY). SLC's director, who is the only staff person assigned to the Commission, also serves as the TCCY Juvenile Justice Division Director and the Statewide Disproportionate Minority Contact Coordinator.

SLC is composed of members of the General Assembly, DCS executive staff, law enforcement, district attorneys, public defenders, a designee from the Administrative Office of the Courts, child advocacy center representatives, and physicians who specialize in child abuse. Appendix 7 (page 73) contains the complete list of statutory SLC members.

SLC annually reviews a sample of second or subsequent child abuse cases investigated by DCS. It communicates its results in an annual report to the General Assembly. The report contains findings and recommendations about how the cases were investigated and retrospective information that may have contributed to a better outcome in the case.

The commission's expenditures can be found in Appendix 8 (page 74) of this report.

AUDIT RESULTS

Finding 1

The Second Look Commission complied with statute, but its impact is inherently limited

While The Second Look Commission (SLC) complied with its statutory mandate, its impact is limited because it meets infrequently and reviews a relatively small number of cases. Additionally, there is no formal mechanism to ensure its recommendations are shared with key stakeholders, especially outside state government.

Sample Size

Although the SLC's current sample selection method complies with state statute, the nature of the commission's membership and meeting frequency limits the number of cases it can reasonably review. As a result, its impact is not as great as it could be.

The SLC reviewed 12 cases in 2015. This included all abuse and neglect death cases that occurred in fiscal year 2014, as well as a sample of cases involving relatively higher

maltreatment, including sexual abuse and drug exposure. To maximize its efforts and make the case reviews more relevant, the SLC reviewed only cases in which the first and second incident of abuse occurred within three years of fiscal year 2014.

This sampling method is consistent with Section 37-3-806(d), *Tennessee Code Annotated*, which limits SLC review to no more than 10% of all cases investigated by DCS in the prior year. However, the actual number reviewed is significantly lower than 10%. For example, in fiscal year 2014, DCS reported 664 children experienced a second or subsequent incident of severe child abuse. SLC reviewed approximately 2% of the eligible cases, well below the 10% maximum. As a result of the small sample size, SLC's impact is limited because its results may not be truly indicative of widespread problems.

SLC's samples are small also because it only meets quarterly due to the heavy schedule of its high profile members. However, infrequent meetings and small samples limit the SLC's impact. The SLC needs to identify and consider other ways to review additional cases. The commission could consider creating committees that review separate cases, as do many of the state's other boards, or the SLC could set aside additional time to review more cases. SLC recommendations based on more case reviews can provide DCS and other stakeholders more reliable, valid, and perhaps pervasive, issues hampering case management.

Communication of Recommendations

Since the 2013 annual report to the General Assembly, the SLC has not followed up on previous years' recommendations and provided the status of those recommendations in its annual reports. As a result, it is not clear that its recommendations are pursued.

For example, if a hypothetical recommendation is made to improve law enforcement activities there is no formal mechanism to communicate these results with official law enforcement bodies. While the SLC does not have formal jurisdiction to compel DCS or other bodies to implement its recommendations, without a formal communication method and follow-up, there is no way to ensure that its recommendations are even known, much less implemented, outside of DCS and the distribution of its annual report.

The SLC should create a formal mechanism, which could be as simple as writing letters to stakeholders, to ensure that key stakeholders are aware of recommendations related to their activities.

Recommendation

The SLC should identify and consider methods to review additional cases, such as creating committees which review separate cases, meeting more frequently, or meeting for a longer period of time.

The SLC should also create a formal mechanism to ensure that key stakeholders are aware of recommendations related to their activities, which could be as simple as writing letters to those stakeholders.

Management's Comment

We concur.

We concur the SLC complies with its statutory mandate.

- In part, TCA 37-3-803(a) states, "The commission shall review an appropriate sampling of cases involving a second or subsequent incident of severe child abuse in order to provide recommendations and findings to the general assembly regarding whether or not severe child abuse cases are handled in a manner that provides adequate protection to the children of this state." The SLC reviews an appropriate sampling of cases involving a second or subsequent incident of severe child abuse in order to provide recommendations and findings to the General Assembly regarding whether or not severe child abuse cases are handled in a manner that provides adequate protection to the children of this state.
- In part, TCA 37-3-803(b) states, "The commission's findings and recommendations shall address all stages of investigating and attempting to remedy severe child abuse." The findings and recommendations included in SLC annual reports address all stages of investigating and attempting to remedy severe child abuse in Tennessee.
- TCA 37-3-803(d)(2) states, "The commission shall provide a report detailing the commission's findings and recommendations from a review of the appropriate sampling no later than January 1, 2012, and annually thereafter, to the general assembly. Such report shall be submitted to the governor, the judiciary and health and welfare committees of the senate and the civil justice committee of the house of representatives." The SLC has submitted the statutorily mandated report to the General Assembly as well as the Governor's Office and SLC members in a timely manner every year it has been in existence. Additionally, the report is posted on the websites of the Tennessee Commission on Children and Youth and the Administrative Office of the Courts, and the recommendations are otherwise distributed and utilized as described below.

While the impact of the SLC may be "inherently limited," it has been substantial. We would submit the impact of virtually any entity could be considered "inherently limited" in spite of significant influence. The impact of the SLC is substantial despite limiting factors suggested in this audit. The meeting frequency, length of meetings and number of cases reviewed do not represent the important contributions of the SLC to improving protection of children in Tennessee.

- From the beginning of the SLC, the core of many of the recommendations has involved strengthening relationships, interactions and investigations of stakeholders,

and improving communication and collaboration, and has contributed to improvements in these areas.

- The SLC has emphasized the need for DCS to conduct issue-driven investigations as opposed to incident-driven investigations, and while there are still opportunities for improvement, DCS has made strides in this arena.

- In part based on recommendations from the SLC, DCS created the CPS Investigator Training Academy (Academy) in 2013 to address SLC findings and recommendations. The Academy includes the following courses that help address SLC findings and recommendations:

    - Medical Evaluation of Child Sexual Abuse;
    - Medical Evaluation of Child Abuse and Neglect;
    - John E. Reid Child Abuse Investigations;
    - John E. Reid Physical Neglect and Child Abuse Reconstruction Techniques;
    - John E. Reid Emerging Trends in Child Sex Abuse;
    - Drug Identification;
    - Recognizing and Documenting Impairment/Drug Use;
    - Meth, Meth Labs and Drug Trucks;
    - CPS Investigations Policy and Effective Use of Work Aids;
    - Juvenile Court Systems;
    - Case Presentation; and
    - Case File Documentation.

- In the 2012 SLC Annual Report, the SLC also recommended creating a Statewide Child Protective Investigation Teams (CPIT) Coordinator and a CPIT Advisory Board. In 2013, DCS appointed a Director of Community Partnerships within the Office of Child Safety. The Director serves as the Statewide CPIT Coordinator. DCS also developed a statewide CPIT Advisory Board. The Statewide CPIT Advisory Board developed by DCS in response to the recommendation by the SLC recently developed a Data and Practice Analysis Workgroup which has been tasked with reviewing the recommendations contained in SLC reports, in addition to other reports that contain recommendations for DCS.

- The 2011 SLC Annual Report noted the terms used by DCS in its policies to classify the results of their investigations are not consistent with the classifications set forth in TCA §37-1-607 ("indicated" and "unfounded" vs. "substantiated" and "unsubstantiated"). DCS made significant terminology changes in efforts to align language with state law and nationally recognized and accepted language used by other child welfare agencies, law enforcement, disability and adult protective services. The term "substantiated" replaced the term "indicated" and the term "unsubstantiated" replaced the term "unfounded." The change was effective January 1, 2014.

- The Director of the SLC is also included in a group of stakeholders who receive notice and opportunity to have input on DCS administrative policy and procedure changes, and as appropriate provides suggestions for changes based on SLC recommendations.

- Sample Size

The SLC has considered the value and feasibility of recommendations to increase the number of cases reviewed and has the following responses:

- Creating committees to review separate cases would take away from the value of the SLC. The statutorily mandated membership categories of the SLC were carefully crafted to include a wide range of professional diversity and a great depth of knowledge. Part of what makes the SLC such a valuable and unique entity is those statutorily mandated membership categories. Members bring their particular areas of expertise to each case the SLC reviews. The interaction among the members includes education of other members and holding each other accountable. Not only does this education and accountability enhance the case review process, it also enhances the practices of the SLC membership and the organizations they represent. Creating committees to review separate cases would diminish the value of the SLC and be inconsistent with the legislative intent of mandating such a professionally diverse and knowledgeable commission.
- The SLC already meets regularly and more often than the statutory requirement to meet quarterly. Each year starting in March, the SLC generally meets every other month to conduct business. In 2015, the SLC held five open and five closed meetings. The open meetings occurred at least every quarter. The SLC is on track to hold five open and five closed meetings in 2016 and six in 2017. Meeting more often is not feasible for several reasons. Each member of the SLC is a highly valued member of an organization, department or entity, or is a business owner. Some of the members are bi-vocational. The SLC has members geographically located from Memphis to Johnson City. Despite the SLC members' commitment to the mission of the SLC, additional meetings would likely create an unnecessary burden in terms of travel and time. Choosing cases from the list provided by DCS, gathering the necessary documentation from across the state, and preparing summaries of the cases generally ranging from 20 to 40 pages is a time consuming process. Each case reviewed by the SLC contains at least two investigations involving substantiated allegations of child abuse. Members of the SLC carefully review the summaries and prepare for meetings. Additionally, some members often research issues they spot in the summaries and bring additional information to share with the SLC during the meetings.
- It is not feasible to meet longer for several reasons. The SLC reviews some of the worst incidents of child abuse in Tennessee. Reading and reviewing these cases can be and often is mentally and physically taxing. The cases reviewed by the SLC are complex and information-dense. They require a diligent and purposeful review. As described by an SLC member, the current time commitment of the SLC is onerous but doable. The length of the meetings is appropriate for dealing with the types of cases the SLC is charged to review. Members of the SLC do not believe more or longer meetings are feasible.

To potentially increase the number of cases reviewed in 2017, the SLC will review cases in which the first and second incident of abuse occurred within two years of each other. Virtually all the cases reviewed by the SLC include substantial activity between the first and second incident of child abuse. Reducing the time between the first and second incidents of abuse may decrease the amount of documentation to collect and review and increase the number of cases the SLC can review. Additionally, restricting case reviews to cases in which the first and second incident of abuse occurred within two years of each other should result in the SLC reviewing the most current practices and policies of all involved stakeholders. Accordingly, the findings and recommendations will impact and improve current practices and policies.

In part, TCA 37-3-806(a) states, "The department of children's services shall, no later than October 1, 2010, provide the commission with a table, detailing profiled cases from the previous fiscal year; thereafter, the department shall provide such table no later than October 1, 2011, and by October 1 annually thereafter, for the previous year." As it has since death cases first appeared in the list in 2013 for review in 2014, the SLC plans to continue to review all death cases included in the table of cases provided by DCS. The SLC may review cases in which the first and second incident of abuse did not occur within two years of each other depending on the potential value of reviewing the case.

The SLC questions the value of reviewing substantially more cases than it reviews currently. Cases reviewed by the SLC are incredibly complex, multi-faceted, lengthy cases involving incidents of severe child abuse. The cases often involve years of abuse and documentation prior to the second or subsequent incident of severe child abuse. The SLC cannot adequately satisfy its statutory obligations and improve its impact with a cursory, hurried or superficial review of more cases.

The first year, the SLC reviewed approximately 20 cases. Based on the experience reviewing so many cases during its inaugural year, SLC members determined they would have a greater impact and provide better quality findings and recommendations if the SLC reviewed fewer cases in greater depth and detail. Reviewing fewer cases allows the SLC to more carefully review the documentation and make a more critical assessment regarding findings and recommendations.

The SLC has generally seen consistent themes, issues and findings related to core issues in cases reviewed over the years. The professionally diverse SLC members report they are not aware of issues the SLC is missing based on the members' expertise. Cases reviewed have exhibited the perennial challenges faced in protective services for vulnerable children in Tennessee: training and supervision; communication/partnership/collaboration across disciplines; sexual abuse; mental health and substance abuse needs, including Neonatal Abstinence Syndrome; and the persistent lack of services consistently available across the state. The findings of the SLC are consistent with the experiences and issues identified by SLC members in their respective fields. The benefit of wrestling with these issues in a safe environment designed for reflection and collaboration is invaluable. The SLC members are able to develop recommendations using the collective wisdom of the group. It is unlikely reviewing more cases would increase the probability of discovering additional systemic issues.

Communication of Recommendations

Since the 2013 annual report to the General Assembly, the SLC has followed up on previous years' recommendations and provided the status of those recommendations in its 2015 SLC report by dedicating a section to reviewing action steps taken by DCS in response to previous years' recommendations.

The SLC Director already contacts key stakeholders prior to the report becoming final to make sure they are aware of the recommendations related to their activities and to give them an opportunity to address any concerns regarding the draft findings and recommendations. In addition to the SLC Director communicating with key stakeholders about findings and recommendations related to their activities, the SLC ensures key stakeholders are aware of recommendations related to their activities a variety of ways.

- The SLC requested time to make presentations to the Tennessee Association of Chiefs of Police, Tennessee Sheriffs' Association and the Council of Juvenile and Family Court Judges. On August 16, 2016, the SLC Director made a presentation to the Council of Juvenile and Family Court Judges regarding findings and recommendations of the SLC related to their activities. In 2017 the SLC will again reach out to these groups, and perhaps others as appropriate based on the recommendations, and more aggressively pursue an opportunity to present information about the SLC findings and recommendations.
- Members of the SLC serve on a variety of committees and task forces, including the Tennessee Joint Task Force on Children's Justice, where the representation also includes law enforcement, district attorneys, juvenile courts, child advocacy centers and other partners. When appropriate, SLC members share findings and recommendations of the SLC with this and various other boards and task forces. In 2013, the Tennessee Joint Task Force on Children's Justice/Child Sex Abuse State Plan references the 2011 SLC report.
- The Training and Professional Development Division of DCS continues to partner with the Tennessee Bureau of Investigation (TBI) to provide the Academy. The Academy is mandatory for all CPS investigators and various community partners are invited to train alongside investigations staff at no cost. By the end of FY 2014-2015, nine classes graduated from the Academy, which included over 150 investigations staff. The Academy is approved by the Peace Officers Standards and Training (POST) Commission, National Association of Social Workers (NASW), and Tennessee Commission on Continuing Legal Education and Specialization. With these approvals, law enforcement, licensed social workers and attorneys receive continuing education hours for their respective disciplines. The SLC Director teaches a course on Juvenile Court at the Academy. The SLC Director presents SLC findings and recommendations of the SLC reports as appropriate with the participants in during this course.
- SLC recommendations are a part of the strategic plans of DCS and the Office of Child Safety.

- The CPIT Advisory Board reviews SLC's findings and recommendations.

However, there is value in creating a formal mechanism to ensure key stakeholders are aware of recommendations related to their activities. It is feasible to create such a mechanism. The SLC will create a formal mechanism to ensure key stakeholders are aware of recommendations related to their activities.

APPENDICES

Appendix 1
Department of Children's Services
Title VI and Other Information

The Tennessee Human Rights Commission (THRC) issues a report, *Tennessee Title VI Compliance Program* (available on its website), that details agencies' federal dollars received, Title VI complaints received, whether each agency's Title VI implementation plan was filed in a timely manner, and any THRC findings taken on an agency. Below are staff demographics, as well as a summary of the information in the latest THRC report for the Department of Children's Services.

According to THRC's fiscal year 2015 report, the department filed its annual implementation plan before the October 1, 2014, due date. During the reporting period, THRC received no complaints regarding the department. Additionally, THRC issued no findings based on its review of the department's implementation plan.

The Department of Children's Services received $144,417,600 from the federal government in fiscal year 2015.

The following table details the department's staff by job title, gender, and ethnicity as of August 2016:

TITLE	MALE	FEMALE	ASIAN	BLACK	HISPANIC	AMERICAN INDIAN	WHITE	OTHER
ACCOUNT CLERK	3	5	1	1	0	0	6	0
ACCOUNTANT 1	0	1	1	0	0	0	0	0
ACCOUNTANT 2	3	0	0	2	0	0	1	0
ACCOUNTANT 3	2	3	0	1	0	0	4	0
ACCOUNTING MANAGER	2	0	1	0	0	0	1	0
ACCOUNTING TECHNICIAN 1	4	28	0	6	1	0	24	1
ACCOUNTING TECHNICIAN 2	1	10	0	2	0	0	9	0
ADMINISTRATIVE ASSISTANT 1	0	1	0	1	0	0	0	0
ADMINISTRATIVE ASSISTANT 2	0	1	0	0	0	0	1	0
ADMINISTRATIVE SECRETARY	4	48	0	8	1	0	42	1
ADMINISTRATIVE SERVICES ASSISTANT 1	0	1	0	0	0	0	1	0
ADMINISTRATIVE SERVICES ASSISTANT 2	2	22	0	6	0	0	18	0

TITLE	MALE	FEMALE	ASIAN	BLACK	HISPANIC	AMERICAN INDIAN	WHITE	OTHER
ADMINISTRATIVE SERVICES ASSISTANT 3	2	21	1	3	0	0	19	0
ADMINISTRATIVE SERVICES ASSISTANT 4	1	3	0	1	0	0	3	0
ADMINISTRATIVE SERVICES ASSISTANT 5	1	2	0	1	0	0	2	0
ADMINISTRATIVE SERVICES MANAGER	2	11	0	4	0	0	9	0
AFFIRMATIVE ACTION DIRECTOR	1	0	0	1	0	0	0	0
AFFIRMATIVE ACTION OFFICER 1	1	0	0	1	0	0	0	0
APPLICATION ARCHITECT	2	0	1	0	0	0	1	0
ASSISTANT COMMISSIONER 2	1	1	0	0	0	0	2	0
ATTORNEY 3	19	53	0	3	0	0	69	0
ATTORNEY 4	3	13	0	0	1	0	15	0
AUDIT DIRECTOR 2	1	0	0	1	0	0	0	0
AUDITOR 2	1	3	0	3	0	0	1	0
AUDITOR 3	1	0	0	0	0	0	1	0
AUDITOR 4	1	0	0	0	0	0	1	0
BUDGET ANALYSIS DIRECTOR 1	1	0	0	0	0	0	1	0
BUDGET ANALYST 2	1	1	0	1	0	0	1	0
BUILDING MAINTENANCE WORKER 2	3	0	0	0	0	0	3	0
BUILDING MAINTENANCE WORKER 3	2	0	0	0	0	0	2	0
CLERK 2	0	2	0	2	0	0	0	0
CLERK 3	1	11	0	5	0	0	7	0
COMMISSIONER 2	0	1	0	0	0	0	1	0
COMMUNITY SERVICES ASSISTANT	0	20	0	10	0	0	10	0
CORRECTIONAL PRINCIPAL	1	2	0	2	0	0	1	0
CORRECTIONAL TEACHER	9	14	0	11	0	0	12	0
CORRECTIONAL TEACHER SUPERVISOR	3	0	0	2	0	0	1	0
DATA ENTRY OPERATOR	0	2	0	0	0	0	2	0
DATABASE ADMINISTRATOR 3	1	0	0	0	0	0	0	1
DCS ADMINISTRATIVE SERVICES MANAGER	2	0	0	0	0	0	2	0
DCS BRIAN A. TECHNICAL ASSISTANCE COMMITTEE MONITOR	0	3	0	1	0	0	2	0

TITLE	MALE	FEMALE	ASIAN	BLACK	HISPANIC	AMERICAN INDIAN	WHITE	OTHER
DCS CALL CENTER CONSULTANT	1	0	0	0	0	0	1	0
DCS CASE MANAGER 1	16	161	1	55	4	0	113	4
DCS CASE MANAGER 2	224	1132	8	493	15	6	825	9
DCS CASE MANAGER 3	89	526	1	218	6	0	382	8
DCS CASE MANAGER 4	57	332	1	143	1	0	242	2
DCS COMMUNITY PARTNERS DIRECTOR	1	0	0	0	0	0	1	0
DCS CORPORAL	32	17	0	34	0	0	15	0
DCS EXECUTIVE DIRECTOR 1	2	3	0	1	0	0	4	0
DCS EXECUTIVE DIRECTOR 2	0	3	0	1	0	0	2	0
DCS FIELD SERVICES HUMAN RESOURCES DIRECTOR 1	0	2	0	1	0	0	1	0
DCS FIELD SERVICES HUMAN RESOURCES DIRECTOR 2	0	1	0	0	0	0	1	0
DCS INSTITUTION SUPERINTENDENT	1	1	0	1	0	0	1	0
DCS INTERNAL QUALITY CONTROL DIRECTOR	0	1	0	0	0	0	1	0
DCS LIEUTENANT	6	5	0	7	1	0	3	0
DCS OFFICER	85	99	0	135	0	0	49	0
DCS PROGRAM COORDINATOR	3	51	0	21	1	0	32	0
DCS PROGRAM DIRECTOR 1	2	13	0	4	0	0	11	0
DCS PROGRAM DIRECTOR 2	6	5	0	3	0	0	8	0
DCS PROGRAM DIRECTOR 3	1	6	0	0	0	0	7	0
DCS PROGRAM MANAGER	5	10	0	4	0	0	10	1
DCS PROGRAM SPECIALIST	6	38	0	19	0	0	25	0
DCS REGIONAL ADMINISTRATOR	0	12	0	3	0	0	9	0
DCS SECURITY MANAGER	2	0	0	1	0	0	1	0
DCS SERGEANT	5	4	0	6	0	0	3	0
DCS SPECIAL INVESTIGATOR 2	2	1	0	1	0	0	1	1
DCS SPECIAL INVESTIGATOR 3	1	2	0	2	0	0	1	0
DCS TEAM COORDINATOR	11	67	0	29	0	0	49	0
DCS TREATMENT MANAGER	1	2	0	1	0	0	2	0
DEPUTY COMMISSIONER 1	0	1	0	0	0	0	1	0
DEPUTY COMMISSIONER 2	2	1	0	0	0	0	3	0

TITLE	MALE	FEMALE	ASIAN	BLACK	HISPANIC	AMERICAN INDIAN	WHITE	OTHER
EDUCATION CONSULTANT 1	3	10	0	3	0	0	10	0
EDUCATION CONSULTANT 2	0	4	0	0	0	0	4	0
EDUCATION CONSULTANT 3	3	0	0	0	0	0	3	0
EDUCATION CONSULTANT 4	0	1	0	0	0	0	1	0
ELIGIBILITY COUNSELOR 2	5	30	0	10	0	0	25	0
EXECUTIVE ADMINISTRATIVE ASSISTANT 2	3	8	1	3	2	0	5	0
EXECUTIVE ADMINISTRATIVE ASSISTANT 3	2	3	0	2	0	0	3	0
FACILITIES MANAGER 1	3	0	0	0	0	0	3	0
FACILITIES SAFETY OFFICER 2	1	1	0	0	0	0	2	0
FACILITIES SAFETY OFFICER 3	1	0	0	0	0	0	1	0
FACILITY ADMINISTRATOR 3	1	0	0	0	0	0	1	0
FIELD SUPERVISOR 2	0	2	0	1	0	0	1	0
FISCAL DIRECTOR 1	4	4	0	2	0	0	6	0
FISCAL DIRECTOR 2	0	3	0	0	0	0	3	0
FISCAL DIRECTOR 3	1	0	0	0	0	0	1	0
FOOD SERVICE DIRECTOR 3	0	1	0	0	0	0	1	0
FOOD SERVICE MANAGER 1	1	2	0	1	0	0	1	1
FOOD SERVICE STEWARD 1	2	7	1	6	0	0	2	0
FOOD SERVICE STEWARD 2	2	3	0	3	0	0	2	0
GENERAL COUNSEL 4	1	0	0	0	0	0	1	0
HUMAN RESOURCES ANALYST 2	0	14	0	8	0	0	6	0
HUMAN RESOURCES ANALYST 3	1	10	0	6	0	0	5	0
HUMAN RESOURCES DIRECTOR 3	0	1	0	1	0	0	0	0
HUMAN RESOURCES MANAGER 2	0	2	0	0	0	0	2	0
HUMAN RESOURCES TECHNICIAN 2	0	7	0	0	0	0	7	0
HUMAN RESOURCES TECHNICIAN 3	0	1	0	1	0	0	0	0
INFORMATION RESOURCE SUPPORT SPECIALIST 2	4	9	0	5	0	0	8	0
INFORMATION RESOURCE SUPPORT SPECIALIST 3	2	2	0	2	0	0	2	0
INFORMATION RESOURCE SUPPORT SPECIALIST 4	2	4	0	2	0	0	3	1
INFORMATION RESOURCE SUPPORT SPECIALIST 5	1	0	0	0	0	0	1	0

TITLE	MALE	FEMALE	ASIAN	BLACK	HISPANIC	AMERICAN INDIAN	WHITE	OTHER
INFORMATION SYSTEMS ANALYST 3	0	4	0	0	0	0	4	0
INFORMATION SYSTEMS ANALYST 4	1	1	1	1	0	0	0	0
INFORMATION SYSTEMS ANALYST SUPERVISOR	0	2	0	1	0	0	1	0
INFORMATION SYSTEMS CONSULT	1	0	0	0	0	0	1	0
INFORMATION SYSTEMS DIRECTOR 1	0	1	0	0	0	0	1	0
INFORMATION SYSTEMS DIRECTOR 2	2	1	1	0	0	0	2	0
INFORMATION SYSTEMS DIRECTOR 3	2	0	0	0	0	0	2	0
INFORMATION SYSTEMS DIRECTOR 4	1	0	0	0	0	0	1	0
INFORMATION SYSTEMS MANAGER 1	5	3	0	3	0	0	5	0
INFORMATION SYSTEMS MANAGER 2	1	0	0	0	0	0	1	0
INFORMATION SYSTEMS MANAGER 3	1	0	0	1	0	0	0	0
LEGAL ASSISTANT	0	10	0	1	0	0	9	0
LEGAL SERVICES DIRECTOR	0	1	0	0	0	0	1	0
LICENSED PRACTICAL NURSE 2	0	1	0	1	0	0	0	0
LICENSED PRACTICAL NURSE 3	0	7	0	4	0	0	3	0
MAINTENANCE MECHANIC 2	1	0	0	1	0	0	0	0
MENTAL HEALTH PRACTITIONER	1	0	0	0	0	0	1	0
PROCUREMENT OFFICER 1	0	2	0	1	0	0	1	0
PROCUREMENT OFFICER 2	1	1	0	0	0	0	2	0
PROGRAM MONITOR 2	1	3	0	1	0	0	3	0
PROGRAM MONITOR 3	0	2	0	1	0	0	1	0
PROGRAM MONITOR 4	0	1	0	0	0	0	1	0
PROGRAMMER/ANALYST 2	2	4	0	2	0	1	3	0
PROGRAMMER/ANALYST 3	4	0	1	0	0	0	3	0
PROGRAMMER/ANALYST 4	7	5	3	0	0	1	6	2
PROGRAMMER/ANALYST SUPERVISOR	3	2	0	1	0	0	4	0
PSYCHIATRIC CHAPLAIN 2	1	0	0	0	0	0	1	0
PSYCHOLOGIST	4	7	0	1	1	0	9	0
PSYCHOLOGY DIRECTOR	0	1	0	0	0	0	1	0

TITLE	MALE	FEMALE	ASIAN	BLACK	HISPANIC	AMERICAN INDIAN	WHITE	OTHER
PUBLIC HEALTH NURSING CONSULTANT 1	1	11	1	2	0	0	8	1
PUBLIC HEALTH NURSING CONSULTANT 2	0	4	0	1	0	0	3	0
RECREATION SPECIALIST 2	2	1	0	2	0	0	1	0
REGISTERED NURSE 3	0	3	0	1	0	1	1	0
REGISTERED NURSE 4	2	2	0	1	0	0	2	1
REGISTERED NURSE 5	0	1	0	0	0	0	1	0
SECRETARY	1	109	1	27	1	0	81	0
SECURITY GUARD 1	1	0	0	1	0	0	0	0
SENIOR PROJECT MANAGER	4	0	0	0	0	0	4	0
STOREKEEPER 2	1	1	0	1	0	0	1	0
TEACHER'S ASSISTANT - CORRECTION	0	4	0	2	0	0	2	0
TRAINING & CURRICULUM DIRECTOR 1	0	4	0	1	0	0	2	1
TRAINING & CURRICULUM DIRECTOR 2	0	1	0	0	0	0	1	0
TRAINING OFFICER 1	4	27	0	12	0	0	18	1
TRAINING OFFICER 2	2	7	0	3	0	0	6	0
TRAINING SPECIALIST 2	2	3	0	1	0	0	4	0
VOCATIONAL INSTRUCTOR - PER SPECIALTY	5	0	0	1	0	0	4	0
GRAND TOTAL	**750**	**3,145**	**26**	**1,394**	**35**	**9**	**2,395**	**36**

Appendix 2
Department of Children's Services
Performance Measures Information

In April 2013, the General Assembly passed the Tennessee Governmental Accountability Act of 2013. This changed the state's requirements for department performance measures. The Department of Children's Services reported two measures in the Governor's customer-focused program.

As stated in the Tennessee Governmental Accountability Act, "accountability in program performance is vital to effective and efficient delivery of government services, and to maintain public confidence and trust in government." In accordance with this act, all executive branch state agencies are required to submit annually to the Department of Finance and Administration a strategic plan and program performance measures. The priority goals for the Department of Children's Services, as reported for August 2016 on the Transparent Tennessee website, are as follows:

Goals

Goal 1: Improve the efficiency of the Child Abuse Hotline by ensuring all calls to the hotline are handled efficiently and professionally for the fastest and safest response.

Measuring the goal:

Metrics	Frequency	Baseline	Target	Prior	Current	Status
Percent of calls answered in 20 seconds or less	Monthly	60%	80%	90%	90%	✓
Percent of dropped calls	Monthly	10%	5%	3%	2%	✓

Goal 2: Improve the percentage of children with current Early Periodic Screening, Diagnosis and Treatment (EPSD&T) health checks through proper and timely health screenings given to every child in state custody.

Measuring the goal:

Metrics	Frequency	Baseline	Target	Prior	Current	Status
Percent of children with EPSD&T exams performed annually	Monthly	90%	95%	94%	95%	✓

Appendix 3
Department of Children's Services
Budget Information

Department of Children's Services
Estimated Budget
For the Fiscal Year Ended June 30, 2016

Source	***Amount***	***Percent of Total***
State	$311,329,900	**42%**
Federal	157,547,700	**21%**
Other	267,317,000	**36%**
Total	**$736,194,600**	**100%***

* Does not add up to 100% due to rounding.
Source: State of Tennessee FY 2016-17 Budget.

Appendix 4
Department of Children's Services
Office of Juvenile Justice
Youth Development Center Incident Reporting SFY 2015-2016
As Presented by the Department

TFACTS Incident Reporting	Total	Youth Development Centers								
		Wilder			Mountain View			Woodland Hills		
		SL1	SL2	Total	SL1	SL2	Total	SL1	SL2	Total
Behavior Management										
Confinement (control)	822	451	1	452	213	60	273	87	10	97
Confinement (disciplinary)	199	136	63	199	0	0	0	0	0	0
Confinement (protective custody)	1	1	0	1	0	0	0	0	0	0
Confinement (emergency)	1	0	0	0	1	0	1	0	0	0
Seclusion	946	15	560	575	47	216	263	48	60	108
Physical Restraint	873	258	0	258	497	1	498	116	1	117
Mechanical Restraint	1280	755	2	757	308	142	450	61	12	73
Mechanical Restraint (transport only)	1165	419	n/a	419	543	n/a	543	203	n/a	203
Use of Chemical Restraint	0	0	0	0	0	0	0	0	0	0
Law Enforcement Involvement										
Runaway/Escape (returned)	4	0	0	0	0	4	4	0	0	0
Runaway/Escape (not returned)	0	0	0	0	0	0	0	0	0	0
Arrest of Youth	7	n/a	0	0	n/a	5	5	n/a	2	2
Police Involvement with Youth	40	0	n/a	0	40	n/a	40	0	n/a	0
Major Event at Agency	1	n/a	0	0	n/a	1	1	n/a	0	0
Abduction	0	n/a	0	0	n/a	0	0	n/a	0	0
Well-Being										
ER Med Treatment - Illness	24	3	0	3	14	0	14	1	6	7
ER Med Treatment - Illness (hospitalization)	1	n/a	0	0	n/a	0	0	n/a	1	1
ER Med Treatment - Injury	504	237	13	250	225	19	244	10	0	10
ER Med Treatment - Injury (hospitalization)	1	n/a	1	1	n/a	0	0	n/a	0	0
Medication Error (no harm)	2	0	n/a	0	2	n/a	2	0	n/a	0
Medication Error (treatment/hospitalization)	0	0	0	0	0	0	0	0	0	0
Mental Health Crisis (treated/released)	105	0	10	10	16	72	88	0	7	7
Mental Health Crisis (hospitalization)	1	n/a	0	0	n/a	0	0	n/a	1	1
ER Use of Psychotropic Meds	0	n/a	0	0	n/a	0	0	n/a	0	0
Persons Related										
Assault (youth/youth)	360	262	4	266	68	0	68	26	0	26
Assault (youth/staff)	254	58	3	61	163	2	165	25	3	28

Fight between youth	172	115	0	115	39	0	39	18	0	18
Search	715	389	0	389	156	0	156	170	0	170
PREA										
Sexual Abuse	35	n/a	6	6	n/a	23	23	n/a	6	6
Sexual Harassment	25	n/a	11	11	n/a	2	2	n/a	12	12
Property Related										
Contraband	162	3	4	7	75	76	151	1	3	4
Property	224	1	49	50	6	129	135	1	38	39
Security Breach	19	0	0	0	0	12	12	0	7	7
Total	**7943**	**3103**	**727**	**3830**	**2413**	**764**	**3177**	**767**	**169**	**936**

*The department categorizes incidents as S1 (insignificant) and S2 (significant).
Chart Source: Department of Children's Services, YDC SFY 2015-2016 Incident Reporting Data.

Behavior Management

Confinement. Confinement is the secure detainment of a youth for the purpose of control or discipline. *Control confinement* is utilized when a youth is deemed a threat of harm to themselves or others. *Protective custody confinement* is utilized when a youth voluntarily requests to be placed in confinement due to legitimate fear for his safety. *Emergency confinement* is when a youth advocates to other youth that they act in a concerted effort and there is clear and present danger that actions would cause harm to other youth/staff; take control of any part of the institution; or cause destruction of property which may significantly alter the living conditions of other youth or jeopardize the security of the facility. *Disciplinary confinement* was a consequence given for violation of major rule infractions.[1]

Seclusion. Seclusion is the confinement of a youth alone in a room or area where the youth is physically prevented from leaving. This definition is not limited to instances in which a youth is confined by a locked or closed door; meaning that if egress is prevented, the youth is secluded. [2]

Physical Restraint. Physical restraint is the use of body contact by staff with a youth to restrict the youth's freedom of movement or normal access to his or her body.

Mechanical Restraint. Mechanical restraint is the application of a mechanical device, material, or equipment attached or adjacent to the youth's body, including ambulatory restraints, which the youth cannot easily remove and that restrict the youth's freedom of movement or normal access to the youth's body. A *mechanical restraint transport* occurs when a youth is mechanically restrained while being transported in a secure vehicle.

Use of Chemical Restraint. The use of a chemical restraint is the discharge, either purposeful or accidental, of chemical defense spray assigned to a staff member.[3]

[1] The Department moved away from using confinement as an incident type within the YDC

facilities on 12/31/15. The Department began using the incident type of seclusion on 01/01/16. This was in accordance of adopting Council of Accreditation practice within the YDCs and moving to their accreditation.

[2] The Department moved away from using confinement as an incident type within the YDC facilities on 12/31/15. The Department began using the incident type of seclusion on 01/01/16. This was in accordance of adopting Council of Accreditation practice within the YDCs and moving to their accreditation.

[3] The Department has not utilized the practice of the use of chemical restraints since the closing of Taft YDC in 2012.

Law Enforcement Involvement

Runaway/Escape. A *runaway* occurs when a youth is away from home, residence or any other residential placement of the youth's parent, guardian or other legal custodian (DCS) without their consent. *Escape* is defined as a youth who leaves the grounds of a YDC without permission or who leaves the care and custody of those transporting them off campus without permission. *Return* is when the youth has been apprehended by law enforcement within 24 hours, or before the IR is entered into the system. *Not returned* is when the youth continues to be on the run, and not apprehended by law enforcement at the time of IR entry.

Arrest of Youth. Arrest of youth occurs when a youth is arrested while in the custody of DCS, and the arrest has been confirmed by a law enforcement agency.

Police Involvement with Youth. Police involvement with youth occurs when a youth is involved in direct contact with a law enforcement agency and they are not arrested.

Major Event at Agency. A major event at an agency is an event at a congregate care location causing a significant disruption to the overall functioning of the program AND necessitates notifying an emergency official. This event affects all, or nearly all, of the youth and staff at the location, (e.g., youth disturbance, riot, fire, flood, etc.).

Abduction. An abduction occurs when a youth is taken from a YDC facility or any other DCS placement by unauthorized individuals (e.g., alleged perpetrators of abuse, non-custodial parents or relatives, etc.).

Well-Being

Emergency Medical Treatment. Emergency medical treatment occurs when a youth is *injured* or suffered an *illness* that requires medical attention. Medical attention can range from agency or YDC staff treatment; clinic; emergency room; to hospitalization.

Medication Error. A medication error is when a medication is not administered according to the prescribing provider and/or according to DCS policies and procedures. Medication errors can range from: *no harm*; *medical treatment*; or *hospitalization*.

Mental Health Crisis. A mental health crisis occurs when a youth is engaged in or experiencing self-injurious behavior, suicidal ideation or behavior, homicidal ideation or behavior, or acute psychotic episode. A youth can be *treated/released* via mobile crisis involvement; intervention by in-house agency clinician/therapist; or emergency room staff. However, there are times where a youth's behavior is severe enough that it requires *hospitalization*, or being certified for psychiatric evaluation.

Emergency Use of Psychotropic Medication(s). Emergency use of psychotropic medications occurs when an emergency one-time dose of a psychotropic medication is used in the event of a psychiatric emergency when all other measures have been determined unlikely to prevent the youth from imminent harm to self and/or others. This does not include youth who have a PRN, psychotropic medication as needed via a prescription.[4]

Persons Related

Assault. An assault is a willful and malicious attack by a youth on another person (this does not include "horseplay"). A youth can assault another youth, or a youth can assault a staff member. A physical *fight between youth* is the willful participation between two or more youth in a physical altercation.

Search. A search is an inspection of the youth's body and can consist of a strip search or a body cavity search. A strip search is a visual inspection of the youth's body. A body cavity search is an in-depth search of the youth's body only by medical, or health care, personnel when probable cause exists that contraband that would threaten the safety and security of the YDC or its personnel[5] is concealed within a body cavity

PREA (Prison Rape Elimination Act)

Sexual Abuse. Sexual abuse of a student by another student, or by a staff member, contractor, or volunteer includes any of the following acts, with or without consent of the student:

a. Contact, penetration, any other intentional touching that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or ratify sexual desire.
b. Any attempt, threat, or request by a staff member, contractor, or volunteer to engage in the activities described in a.
c. Any display by a staff member, contractor, or volunteer of his or her uncovered genitalia, buttocks, or breast in the presence of a student.
d. Voyeurism by a staff member, contractor, or volunteer.

Sexual Harassment. Sexual harassment is any repeated and unwelcome sexual advance, request for sexual favors, or verbal comment, gesture, or action of a derogatory or offensive sexual nature by one student directed toward another student, or to a student by a staff member, contractor, or volunteer.

[4] Emergency Use of Psychotropic Medication(s) is an incident type that does not apply to the

Department's YDC facilities.
[5] Note that in order for a body cavity search to occur, the YDC must first receive Central Office approval.

Property Related

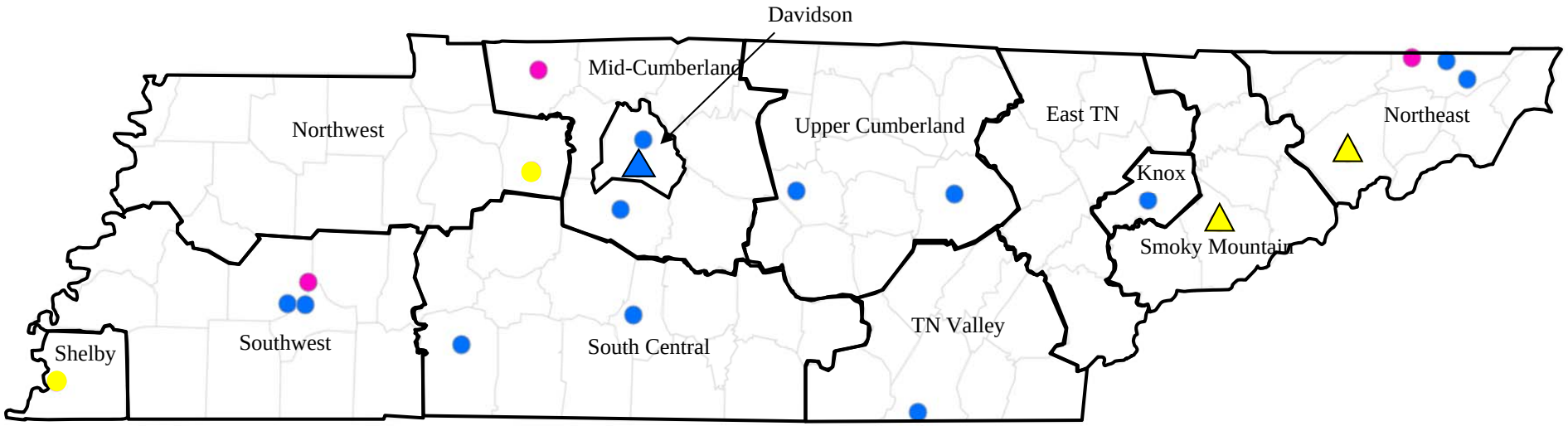
Contraband. Any item possessed by an individual or found within the facility that is illegal by law or that is expressly prohibited by those legally charged with the responsibility for the administration and operation of the facility or program and is rationally related to legitimate security, safety or treatment concerns.

Property. Any state property that is lost, stolen, missing or damaged with or without intent by a youth. Any personal property that is damaged, missing or stolen by a youth while the owner is in the performance of their duties for the State or on State property.

Security Breach. A security breach is a violation of established security procedures that occurs either on campus or during the transport of a youth that places staff or youth at risk. It may also include the loss of security equipment such as keys, restraints, radios or tools.

Source: Department of Children's Services.

Level 2 Contract Providers by Location and Gender Served



Location with Multiple L2 Male Facilities on Site

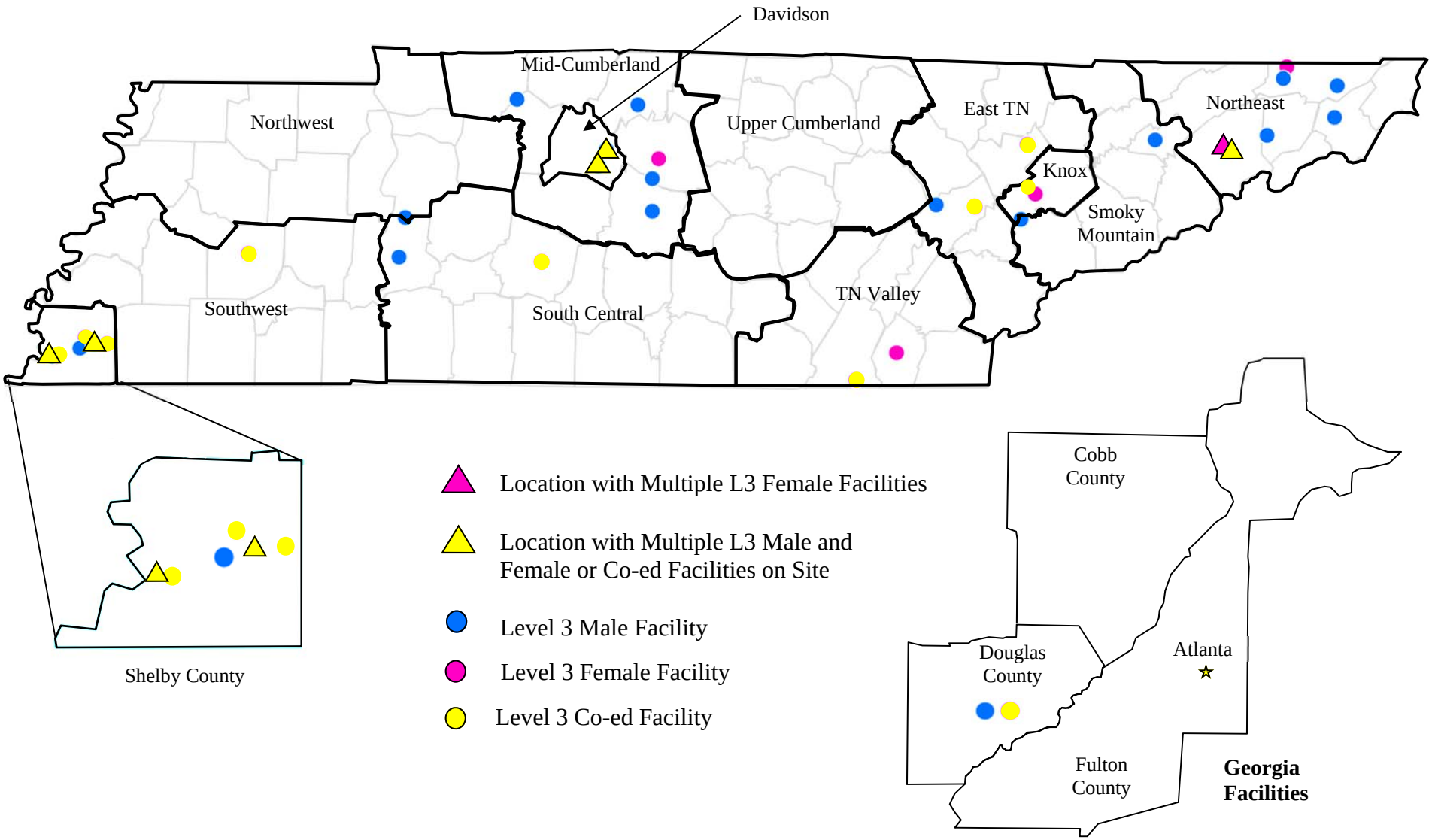
Location with Multiple L2 Male and Female or Co-ed Facilities on Site

Level 2 Male Facility

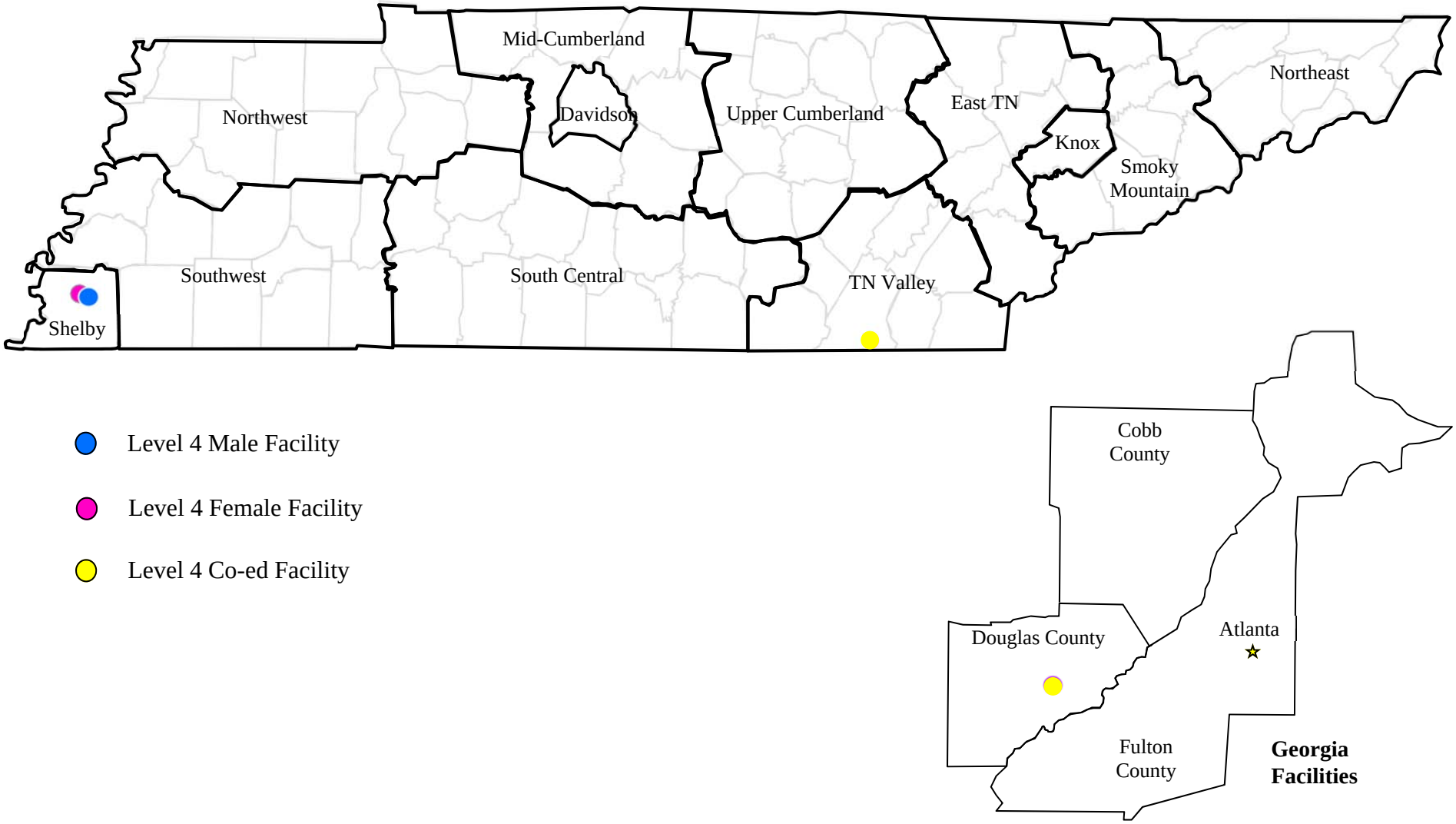
Level 2 Female Facility

Level 2 Co-ed Facility

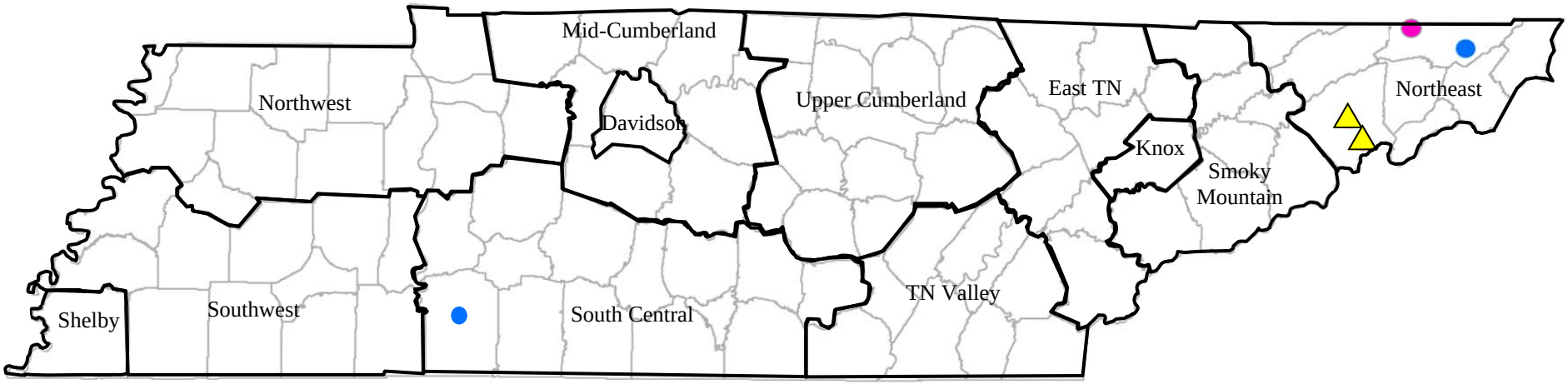
DCS Level 3 Contract Providers by Location and Gender Served



DCS Level 4 Contract Providers by Location and Gender Served



DCS Contract Primary Treatment Centers by Location and Gender Served

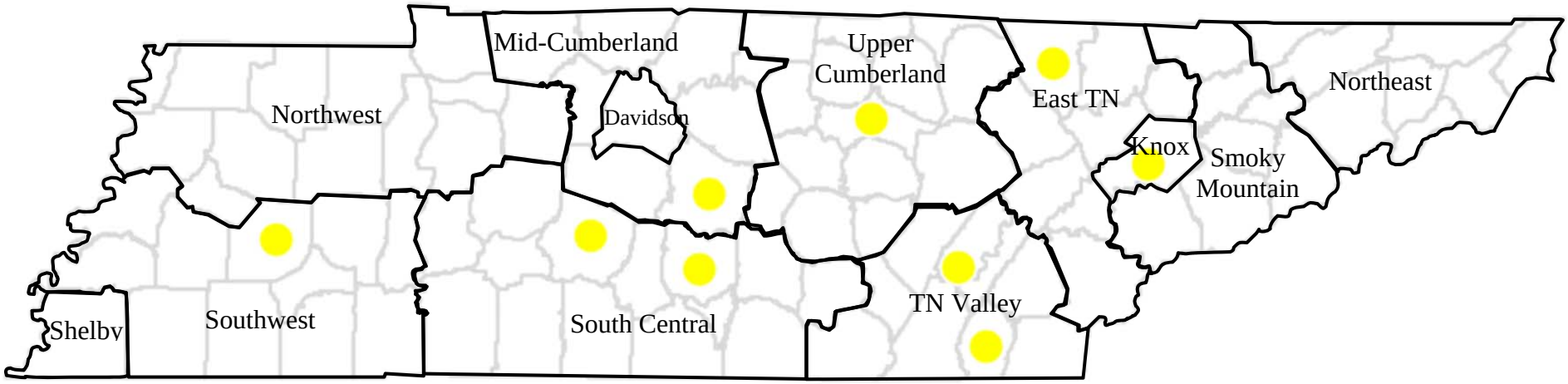


Location with Multiple PTC Male and Female or Co-ed Facilities on Site

Male Primary Treatment Center

Female Primary Treatment Center

DCS Contract Detention Centers by Location



Co-ed Detention Center

Appendix 6
Second Look Commission
Section 37-3-804, *Tennessee Code Annotated,* Membership

37-3-804. Membership.

(a) Members of the commission shall be as follows:

(1) The director of the Tennessee bureau of investigation or the director's designee;

(2) The executive director of the commission on children and youth or the director's designee;

(3) The executive director of Tennessee's chapter of children's advocacy centers or the director's designee;

(4) The commissioner of children's services or the commissioner's designee;

(5) The director of the administrative office of the courts or the director's designee;

(6) Two (2) members of the house of representatives to be appointed by the speaker of the house of representatives;

(7) Two (2) senators to be appointed by the speaker of the senate;

(8) Two (2) law enforcement officers appointed by the governor with experience investigating severe child abuse cases: one (1) such officer shall be from a county with a population of more than two hundred fifty thousand (250,000), according to the 2000 federal census or any subsequent federal census, and one (1) such officer shall be from a county with a population of less than two hundred fifty thousand (250,000), according to the 2000 federal census or any subsequent federal census;

(9) A district public defender appointed by the district public defenders conference;

(10) A district attorney general appointed by the district attorneys general conference;

(11) A physician with experience conducting exams used to determine whether or not severe child abuse has occurred, appointed by the commission's co-chairs;

(12) An attorney with recognized expertise representing children in child abuse and neglect proceedings, appointed by the commission's co-chairs; and

(13) Two (2) individuals with experience as advocates for children from the nonprofit sector, appointed by the commission's co-chairs.

(b) (1) (A) Members of the commission set out in subdivisions (a)(1)-(5) shall serve on the commission as long as they hold the positions designated in subdivisions (a)(1)-(5).

(B) (i) Except as otherwise provided for in subdivision (b)(2), members of the commission appointed pursuant to subdivisions (a)(6)-(13) shall serve four-year terms.

(ii) Notwithstanding any other provision of this section to the contrary, following three (3) successive absences by a member appointed pursuant to subdivisions (a)(6)-(13) from commission meetings, the co-chairs may declare a vacancy and request that a new member be appointed pursuant to this section who meets the criteria of the replaced member.

Appendix 7
Second Look Commission
Members as of October 31, 2016

Member Name	Statutory Role
Senator Doug Overbey	General Assembly
Representative Mark White	General Assembly
Senator Dolores Gresham	General Assembly
Representative John DeBerry	General Assembly
Carla Aaron	DCS designee
Karen Jointer	Child Advocacy Center
Brenda Davis	Child Advocate from non-profit sector
David Doyle, Esq.	District Public Defender
Valerie Schabilion	Law enforcement officer from a county with population less than 250,000; Northwest Region
Patty Tipton	Law enforcement officer from a county with population more than 250,000; East Region
Linda O'Neal	TCCY Executive Director
Debra Quarles Mills, M.D.	Physician with experience conducting exams used to determine whether severe child abuse occurred
Charme P. Allen	District Attorney General
Cynthia Wyrick	Attorney with expertise representing children in abuse and neglect proceedings
John Simmons	Director of Tennessee Bureau of Investigation designee
Deborah Taylor Tate	Administrative Office of the Courts
Trudy Hughes	Child advocate from non-profit sector

Source: Second Look Commission.

Second Look Commission
Member Ethnicity and Gender
As of October 31, 2016

	White	Black
Male	4	1
Female	11	1

Source: Second Look Commission.

Appendix 8
Second Look Commission
Expenditures (Unaudited)
Fiscal Year 2015

Salary/Longevity	$75,412.82
Travel	996.76
Supplies & Materials	121.29
Professional and Administrative Services – Third Party	286.31
Professional Services – From Another State Agency – Telephone	501.42
Total	**$77,716.10**

Source: Second Look Commission.

Note: The Second Look Commission does not have any revenue sources. The commission is administratively attached to the Tennessee Commission on Children and Youth.