Audit Highlights

Highlights of performance audit report on the Division of Child and Family Services issued on March 22, 2022.

Legislative Auditor report # LA22-08.

Background

The Division of Child and Family Services (Division) was established in 1991. The Division's mission is to provide support and services to assist Nevada's children and families in reaching their full human potential. The Division recognizes that children, youth, and families thrive when they live in safe, permanent settings; experience a sense of sustainable emotional and physical wellbeing; and receive support to consistently make positive choices for family and the common good.

Child welfare and protective services functions in three regional services areas: northern, southern, and rural. The Division is responsible for Child Protective Services (CPS) activities and children in state custody in the rural service area, which includes all counties other than Washoe and Clark. Both the northern and southern service areas are state-supervised, county-administered child welfare delivery systems.

CPS receives reports from mandatory reporters and the public about alleged child maltreatment. Reports are assessed or screened for statements or allegations of child abuse and neglect. As part of its responsibilities to care for children in state custody, the Division supports the health of children by ensuring they receive necessary medical, dental, and mental health care.

Purpose of Audit

The purpose of the audit was to evaluate whether the Division adequately ensures the safety and welfare of children for certain Division activities, including maltreatment report response and the supervision of medical care of children in state custody. The audit included a review of the Division's activities for the 18-month period of January 1, 2019, to June 30, 2020, including previous years for case management activities.

Audit Recommendations

This audit report contains 11 recommendations to improve processing of maltreatment reports and oversight of health care services for children in state custody.

The Division accepted the 11 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on June 15, 2022. In addition, the 6-month report on the status of audit recommendations is due on December 15, 2022.

Management of Maltreatment Reports and Child Health

Division of Child and Family Services

Summary

The Division did not completely process certain maltreatment reports and was unaware that some reports lacked supervisory review. In addition, Division staff and management did not always employ adequate report recordkeeping practices and had the opportunity but did not complete necessary investigations in response to certain maltreatment reports. Furthermore, the Division does not assess comprehensive Medicaid claims of children in state custody to identify injuries or medical evaluations indicating potential abuse and neglect. Without effective management of maltreatment incidents and reports, children were exposed to increased risk of harm and neglect.

The Division was lacking in its monitoring of health care for children in state custody. For instance, the Division did not ensure children received required preventative health and dental care or that visits were properly documented in Unified Nevada Information Technology for Youth (UNITY). In addition, the Division's prescribed health care schedule for children in state custody was not updated to align with medical standards. When children do not receive required health care, they are at an increased risk of preventable illness. Maintaining complete records of health care for children in state custody facilitates continuity of care and supports the welfare of children.

Key Findings

Division management was unaware that certain maltreatment reports lacked complete supervisory review and were not processed according to statute and policy. Of over 4,800 rural reports received in calendar year 2019, 107 indicated a lack of supervisory review, which means the report was not completely processed. Unprocessed reports included serious allegations such as physical abuse, parental drug abuse, domestic violence, and child self-harm. Out of the 107 reports, 35 reports identifying alleged victims, perpetrators, and/or maltreatment incidents did not receive complete or timely supervisory review until we notified the Division of the oversight. We assessed all 107 reports and identified 18 in which the welfare of the children was potentially at immediate risk. We promptly notified the Division of these 18 reports. The Division confirmed these reports had not received proper oversight and assessed the safety of the children involved. (page 7)

The case histories associated with 11 of 107 maltreatment reports showed that children were exposed to additional risk of abuse and neglect because of inadequate or untimely report processing by the Division. The Division also delayed reporting alleged crimes of sexual abuse against children to law enforcement. (page 8)

The Division did not have adequate recordkeeping and record retention practices for certain maltreatment reports. Of 133 reports, 11 reports had inadequate report documentation. Examples of inadequate report documentation included insufficient or inaccurate documentation of alleged incidents, alleged perpetrators, alleged victims, or Division actions in response to reports. (page 8)

Some reports were deleted from UNITY even though those contained important incident-related information regarding alleged victims or instances of abuse and neglect. (page 9)

The Division had the opportunity but did not complete necessary investigations in response to allegations of abuse and neglect for 7 of 133 reports we assessed that were received in 2019. Reports not investigated by the Division included allegations of neglect, child abuse, inadequate shelter, failure to protect, threatened violence against a child, potential self-harm, and domestic violence. (page 10)

The Division does not analyze Medicaid claims of children in state custody for injuries or medical assessments indicative of abuse and neglect. Both state and federal entities have evidenced the child welfare benefits of utilizing Medicaid claims to identify potential incidents of child abuse and neglect. The Division was not aware of this best practice. (page 11)

Many children in state custody in 2019 did not receive required preventative health and dental care. A total of 29% of children did not receive annual preventative health care and 28% did not receive any dental care. (page 13)

For 159 of 198 (80%) children in state custody for all of 2019, the Division did not maintain complete health records in UNITY. Division policies are inadequate to ensure all health care records are obtained and entered into UNITY. (page 14)

The Division did not update timely its preventative health care schedule in policy for children in state custody to align with American Academy of Pediatrics recommendations. (page 15)

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