Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

TEXAS DID NOT ALWAYS ENSURE THAT ALLEGATIONS AND REFERRALS OF ABUSE AND NEGLECT OF CHILDREN ELIGIBLE FOR TITLE IV-E FOSTER CARE PAYMENTS WERE RECORDED AND INVESTIGATED IN ACCORDANCE WITH FEDERAL AND STATE REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

May 2017
A-06-15-00049

Office of Inspector General

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Report in Brief
Date: May 2017
Report No. A-06-15-00049

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Texas Did Not Always Ensure That Allegations and Referrals of Abuse and Neglect of Children Eligible for Title IV-E Foster Care Payments Were Recorded and Investigated in Accordance With Federal and State Requirements

Why OIG Did This Review

The United States Senate Committee on Finance outlined concerns about the safety and well-being of foster care children in an April 2015 letter addressed to State governors. These issues were highlighted in a media report on the deaths of children in foster care. Accompanying the deaths were allegations of negligence as a contributing factor and evidence of sexual and physical abuse, sometimes after clear warning signs.

Our objective was to determine whether the Texas Department of Family and Protective Services (State agency) ensured that allegations and referrals of abuse and neglect of children eligible for foster care payments under Title IV-E of the Social Security Act, as amended (P.L. No. 74-271, Aug. 14, 1935) (the Act), were recorded, investigated, and resolved in accordance with Federal and State requirements.

How OIG Did This Review

We reviewed 100 case files of reported complaints related to allegations and referrals of abuse and neglect of children made during the period October 2014 through June 2015. Allegations included physical and sexual abuse, physical and medical neglect, and neglectful supervision. We evaluated and tested the State's procedures for monitoring, tracking, and investigating those complaints.

What OIG Found

Of the 100 reported cases of abuse and neglect that we reviewed, 54 were investigated in accordance with Federal and State requirements. Of the remaining 46 cases (12 cases had more than 1 issue), we found that Texas did not (1) submit 17 investigation reports for supervisory approval within 30 days as required or (2) ensure, in 41 cases, that investigators and their supervisors conducted and documented interim meetings within 20 days as required.

Texas's failure to submit investigations for supervisory review within required timeframes and failure to conduct and document interim meetings in a timely manner undermines the State's internal controls for providing oversight of the investigation and could place foster care children at risk. However, we recognize that meeting established timeframes should not come at the expense of performing high quality investigations. As such, both quality and timeliness are important factors to be considered when determining required timeframes to submit investigations for supervisory review.

Texas completed all investigations and assigned a disposition that resolved each of the 100 sample cases reviewed.

What OIG Recommends and Texas Comments

We recommend that Texas (1) revise its policy of requiring a 30-day timeframe for submitting an investigation report to a period that ensures both quality and timeliness in completing the investigation and (2) ensure that interim meetings between investigators and supervisors are held and documented within the required timeframes.

Texas agreed that our findings accurately reflect the conditions that were found; however, it disagreed with the title, tone, and overall conclusion of the report and did not agree that Federal requirements were not met. After reviewing the Texas's comments, we maintain that the title, tone, and overall conclusion of the report are an accurate reflection of the audit. Additionally, Federal law requires that States develop standards related to safety and that those standards apply to any foster home or childcare institution receiving funds under Title IV-E of the Act.

The full report can be found at https://oig.hhs.gov/oas/reports/region6/61500049.asp.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

The United States Senate Committee on Finance outlined concerns about the safety and well-being of foster care children in an April 2015 letter addressed to State governors and sought information about the States' use of private entities or organizations to administer some or all of their foster care programs. The letter describes the child welfare system as a "complex structure consisting of overlapping Federal, State, County and Tribal laws and practices carried out by a mix of public and private entities. At times, this structure leads to finger pointing and confusion when it comes to the question of who is responsible when something goes wrong." These issues were highlighted in a media report[1] on the deaths of children in foster care. Accompanying the deaths were allegations of negligence as a contributing factor and evidence of sexual and physical abuse, sometimes after clear warning signs, according to the article. To determine whether vulnerabilities in the complaint and investigation processes exist, we are performing reviews of foster care agencies in several States, including Texas.

OBJECTIVE

Our objective was to determine whether the Texas Department of Family and Protective Services (State agency) ensured that allegations and referrals of abuse and neglect of children eligible for foster care payments under Title IV-E of the Social Security Act, as amended (P.L. No. 74-271, Aug. 14, 1935) (the Act), were recorded, investigated, and resolved in accordance with Federal and State requirements.

BACKGROUND

Federal Foster Care Program

Title IV-E of the Act established the Federal foster care program, which helps States to provide safe and stable out-of-home care for children until they are safely returned home, placed permanently with adoptive families, or placed in other planned arrangements. At the Federal level, the Administration for Children and Families administers the program. The State agency is responsible for administering the program at the State level.

The Act requires a State to submit a plan that designates a State agency that will administer the program for the State (the Act § 471(a)(2)). Among other requirements, the plan must mandate that the State agency report and provide information to an appropriate agency or official regarding known or suspected instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving Foster Care Program aid (the Act §§ 471(a)(9)(A) and (B)). The State plan also must provide for the establishment or designation of a State authority or authorities that will be responsible for establishing and

[1] Mother Jones, "The Brief Life and Private Death of Alexandria Hill." Available online at http://www.motherjones.com/politics/2015/01/privatized-foster-care-mentor. Last accessed on January 18, 2017.

maintaining standards for foster family homes and childcare institutions, including standards related to safety, and require that the State shall apply the standards to any foster family home or childcare institution receiving funds under sections IV-E or IV-B of the Act (the Act § 471(a)(10)).

Foster Care Program in Texas

In Texas, the Department of Family and Protective Services (DFPS) is the State agency that administers the Title IV-E program and is also responsible for protecting children in the foster care program from abuse or neglect. Private for-profit and nonprofit Child Placing Agencies (CPAs) secure placements for many children in the Title IV-E program. CPAs are licensed by the State and place children in residential childcare settings, including agency foster homes.[2] Agency foster homes provide care for six or fewer children for 24 hours a day, are used only by a licensed child-placing agency, and meet DFPS standards.[3] CPAs regulate their own foster homes[4] but must comply with minimum standards developed by DFPS.[5] The State agency contracted with 307 CPAs that provided care to 14,846 of the 19,926 Title IV-E-eligible foster children in residential child care during the period October 1, 2014, through June 30, 2015.

The Statewide Intake (SWI) division of the State agency is responsible for assessing all reports of abuse and neglect of children and abuse, neglect, or exploitation of adults 65 or older and adults with disabilities.[6] SWI also determines the correct State agency program[7] with jurisdiction to investigate the reports. SWI documents every call, fax, letter, and Internet report in the Information Management Protecting Adults and Children in Texas (IMPACT) computer system. IMPACT is a web-based automated system that allows staff across the State immediate access to all stored data. The SWI intake specialist assigns a priority to the report based on the circumstances described by the reporter and routes the intake to the correct State agency program and field office. Priority 1 and priority 2[8] intakes represent abuse and neglect of a child, which is the focus of our audit, and they are the highest priorities SWI assigns

[2] Texas Human Resources Code (THRC) § 42.002(12).

[3] THRC § 42.002(11).

[4] 40 Texas Administrative Code (TAC) § 745.37(3).

[5] See "Minimum Standards for Child Placing Agencies" (June 2015) (CPA Minimum Standards), https://www.dfps.state.tx.us/Child_Care/documents/Standards_and_Regulations/749_CPA.pdf.

[6] See https://www.dfps.state.tx.us/About_DFPS/Statewide_Intake.

[7] Adult Protective Services, Child Protective Services, Day Care Licensing, or Residential Child-Care Licensing.

[8] If an allegation or referral concerns the death of a child or an immediate threat of serious physical or emotional harm or death, SWI assigns the investigation a priority 1. If an allegation or referral concerns abuse or neglect, and the child is currently safe or is not at immediate risk of serious physical or emotional harm as a result of the abuse or neglect, SWI assigns the investigation a priority 2 (the Handbook §§ 6222.1 and 6222.2).

to a report. The other priorities that can be assigned represent nonabuse or neglect allegations, such as minimum standards violations, which pose a low risk of harm to the health or safety of children in care.

The priority assigned to the report determines the time frame[9] in which the investigation must be initiated in the field.

The Residential Child-Care Licensing Division is charged with investigating all allegations of abuse and neglect of children in DFPS conservatorship,[10] including those in agency foster homes.[11] An investigation is completed when necessary contacts have been made, the safety of the children has been secured, and findings have been determined.[12]

State Requirements

Chapter 42 of the Texas Human Resources Code requires that the State agency regulate childcare and child-placing activities in Texas through a licensing program;[13] create and enforce minimum standards to protect the health, safety, and well-being of children placed in residential childcare settings, including agency foster homes;[14] and investigate alleged abuse and neglect in residential childcare settings, including agency foster homes.[15] Licensing staff must follow the procedures and policies laid out in the State agency's *Licensing Policies and Procedures Handbook* (the Handbook) to meet the requirements laid out in the licensing statutes and State agency's rules.[16]

HOW WE CONDUCTED THIS REVIEW

We obtained State data on allegations and referrals of abuse and neglect of Title IV-E-eligible foster children for which SWI assigned an investigation priority 1 or priority 2 for the period October 1, 2014, through June 30, 2015. We sorted the population of 525 cases (172 priority 1

[9] The State agency requires that priority 1 investigations of abuse and neglect be initiated as soon as possible, but no later than 24 hours after the SWI division receives the intake report. The State agency requires that priority 2 investigations of abuse and neglect be initiated as soon as possible, but no later than 72 hours after the SWI division receives the intake report (the Handbook § 6361).

[10] The State agency legally assumes parental responsibility for the child (Child Protective Services Handbook 6100).

[11] TAC § 745.8413; Texas Family Code § 261.401(b); CPA Minimum Standards, p.vi.

[12] The Handbook § 6600.

[13] THRC § 42.0001.

[14] THRC § 42.0001.

[15] THRC § 42.044(c).

[16] The Handbook § 1120.

and 353 priority 2) by type and determined that 337 (125 priority 1 and 212 priority 2) of these cases occurred in residential settings in which children were placed by CPAs. We selected 100 cases (33 priority 1 and 67 priority 2) from the 15 CPAs that had the highest number of allegations or referrals of abuse and neglect during our audit period for Title IV-E-eligible foster care children who resided in an agency foster home at the time the incident occurred. The 100 cases were reported by 89 professionals[17] and 11 other reporters.

SWI received 82 of these allegations by phone and 18 by Internet. Allegations we reviewed related to physical and sexual abuse, medical neglect, and neglectful supervision.

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.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency did not always ensure that allegations and referrals of abuse and neglect for children in foster care covered by Title IV-E of the Act were recorded and investigated in accordance with Federal and State requirements. Of the 100 reported cases (33 priority 1 and 67 priority 2) of abuse and neglect that we reviewed, 54 were investigated in accordance with Federal and State requirements. Of the remaining 46[18] cases, we found that the State agency:

- did not submit 17 investigation reports for supervisory approval within 30 days as required and

- did not ensure, in 41 cases, that investigators and their supervisors conducted and documented interim meetings within 20 days as required.

[17] Texas Family Code states that certain individuals designated as "professionals" are required to report suspected child abuse or neglect within 48 hours of initial suspicion. Texas law defines a "professional" for this purpose as "an individual who is licensed or certified by the State or who is an employee of a facility licensed, certified, or operated by the State and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers" (Texas Family Code, § 261.101(b)).

[18] Twelve cases had more than one issue.

The State agency completed all investigations and assigned a disposition that resolved each of the 100 sample cases reviewed.

THE STATE AGENCY DID NOT SUBMIT CASES FOR SUPERVISORY APPROVAL WITHIN THE REQUIRED TIMEFRAME

The State agency requires that, upon completion of a priority 1 or priority 2 investigation, investigators submit their reports to their supervisor for approval. Investigators must submit investigation reports no later than 30 days after the date of the intake report unless they get approval to extend the timeframe. After a supervisor reviews the investigation report, the supervisor or a secondary approver is required to either approve the report and close the investigation or reject the report and continue the investigation (the Handbook §§ 6810 and 6820).

For 17 of the 100 cases reviewed (4 priority 1 and 13 priority 2), investigators did not submit investigation reports within the required 30-day timeframe, with 4 cases being more than 30 days late. For 2 of the 17 cases (1 priority 1 and 1 priority 2), the investigators' supervisor granted extensions to the investigators. However, the investigation reports were submitted after the extensions ended, and no additional extensions were granted.

According to one State agency official, the investigation reports were not submitted for approval in the required timeframe because State agency officials wanted to place more emphasis on performing quality work than on completing the investigations in the prescribed timeframe.

See Appendix B for more information on the types of allegations and priority levels assigned.

THE STATE AGENCY DID NOT ENSURE THAT INVESTIGATORS AND SUPERVISORS CONDUCTED AND DOCUMENTED INTERIM MEETINGS IN A TIMELY MANNER

Investigators must meet with a supervisor at least once during all investigations involving allegations of abuse or neglect. These meetings must occur no later than the 20th day after SWI receives the intake report. The interim meeting includes discussions of the information and evidence obtained up to that time and any additional tasks to be completed before a disposition can be made. Following the interim meeting, the investigator is required to document the information discussed (the Handbook § 6460).

The State agency did not conduct an interim meeting within 20 days after SWI received the intake report for 41 of the 100 cases reviewed (13 priority 1 and 28 priority 2), with 3 cases being more than 20 days late. Three of the forty-one cases were disposed as "reason to believe."[19]

[19] A preponderance of evidence indicated that abuse, neglect, or exploitation occurred (the Handbook § 6622.3).

In addition, for nine cases there were no records showing that the required interim meeting occurred at all. For these nine cases, a supervisor ultimately approved and closed the investigation. State officials said that investigators and the supervisors informally discuss the investigations but that the discussions are not always documented. State agency officials also said that a workgroup was looking at the issue of interim meetings to determine whether supervisors should continue to adhere to a 20-day timeframe.

See Appendix B for more information on the types of allegations and priority levels assigned.

THE STATE AGENCY ENSURED THAT ALLEGATIONS AND REFERRALS OF ABUSE AND NEGLECT WERE RESOLVED IN ACCORDANCE WITH STATE REQUIREMENTS

The State agency requires that an investigator assign a disposition to each allegation at the end of the investigation.[20] An investigation is completed when all necessary contacts have been made, the safety of the children has been secured, and findings have been determined (the Handbook § 6600).

The State agency completed all investigations and assigned a disposition to each of the 100 sample cases reviewed. Specifically, 94 were disposed as "ruled out,"[21] 4 were disposed as "reason to believe," and 2 were disposed as "administrative closure."[22] In three of the four cases for which the disposition was believable, the child was either removed from the foster family home or was no longer in the foster family home. In one of the four cases, the foster family home was closed.

CONCLUSION

The State agency's failure to submit investigations for supervisory review within required timeframes and failure to conduct and document interim meetings in a timely manner undermines the State agency's internal controls for providing oversight of the investigation and could place foster care children at risk. However, we recognize that meeting established timeframes should not come at the expense of performing high quality investigations. As such, both quality and timeliness are important factors to be considered when determining required timeframes to submit investigations for supervisory review.

[20] The Handbook § 6622.3.

[21] A preponderance of evidence indicated that abuse, neglect, or exploitation did not occur (the Handbook § 6622.3).

[22] If after conducting investigative actions, the investigator determines that the operation is not subject to the State agency's regulation, the investigator notifies law enforcement, Child Protective Services, or any other State agency with regulatory responsibility and administratively closes the investigation (the Handbook § 6557).

RECOMMENDATIONS

We recommend that the State agency:

- revise its policy of requiring a 30-day timeframe for submitting an investigation report to a period that ensures both quality and timeliness in completing the investigation and

- ensure that interim meetings between investigators and supervisors are held and documented within the required timeframes.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed that our findings accurately reflect the conditions that were found; however, the State agency disagreed that the paperwork issues suggest "some type of infirmity in the quality of the investigations …." The State agency also disagreed with the title, tone, and overall conclusion of the report. Regarding the title and tone, the State agency said that it "sensationalizes the underlying findings and misleads readers regarding the true content of the report." As for the conclusion, the State agency disagreed that foster children could have been placed at risk. Additionally, the State agency acknowledged our concerns with the State requirements but did not agree that Federal requirements were not met.

The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that the title, tone, and overall conclusion of the report are an accurate reflection of the audit conditions we found.

Additionally, Federal law requires that the State Agency develop standards related to safety and that those standards apply to any foster home or childcare institution receiving funds under Title IV-E of the Act. Texas violated the standards that it was required to implement under Federal law. Our report finds that the State agency failed to follow its own policies in that regard, as required by Federal law.

The State's comments suggest that there is no actual evidence that the "paperwork concerns" represent actual deficiencies in the investigations. However, the State agency's failure to follow its own policies undermines the State agency's internal controls for providing oversight of investigations and ensuring the safety and well-being of foster care children throughout the complaint resolution process.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We obtained State data on reports of all allegations and referrals of abuse and neglect of Title IV-E-eligible foster children for which SWI assigned a priority 1 or priority 2 investigation for the period October 1, 2014, through June 30, 2015. We sorted the universe of 525 cases (172 priority 1 and 353 priority 2) by type and determined that 337 (125 priority 1 and 212 priority 2) of these cases occurred in residential settings in which children had been placed by a CPA. We selected 100 cases from 15 different CPAs that had the highest number of allegations and referrals of abuse and neglect during our audit period for Title IV-E foster care children who resided in an Agency foster home at the time the incident occurred. Each case file contained the details of the allegation, the time and method of the investigation's initiation, interviews with the potential victim(s) and the foster parent(s), notification to law enforcement, a supervisory review, an investigation completion date, and the supervisor's approval of the investigation.

We evaluated and tested the State agency's procedures for monitoring, tracking, and investigating those complaints by reviewing the State agency's case files. In addition, we visited 4 of the 15 CPAs to review their policies and procedures for handling allegations of abuse and neglect of foster care children.

We did not assess the State agency's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit objective.

We conducted fieldwork at the State agency's offices in Austin, Dallas, and Houston, Texas, from July through September 2015, and at four CPAs in Round Rock, Tyler, and Spring (2 CPAs), Texas, in November and December 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and the State agency licensing policy and procedures handbook related to reporting allegations and referrals of abuse and neglect;

- interviewed State agency officials regarding the State agency's monitoring, tracking, and investigation of allegations or referrals of abuse and neglect cases involving Title IV-E foster care children;

- interviewed CPA officials regarding the reporting of allegations and referrals of abuse and neglect and the process for monitoring, tracking, and investigation of those cases;

- obtained a computer-generated file from SWI representing all allegations of abuse and neglect of Title IV-E foster care children during our audit period;

- selected for review a judgmental sample of 100 cases in which the child was placed in a foster home by a CPA at the time the incident occurred;

- assessed the intake and investigation process and timeliness of the selected sample cases; and

- discussed our findings with State agency officials.

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.

APPENDIX B: TYPE OF ALLEGATIONS AND PRIORITY LEVELS FOR SAMPLES REVIEWED

Table 1: Samples Reviewed

Type of Allegation	Priority 1	Priority 2	Total
Medical neglect	1	1	2
Neglectful supervision	14	19	33
Physical abuse	14	34	48
Physical neglect	0	5	5
Sexual abuse	4	8	12
Total	**33**	**67**	**100**

Table 2: Cases Not Submitted For Supervisory Approval Within the Required Timeframe

Type of Allegation	Priority 1	Priority 2	Total
Medical neglect	1	0	1
Neglectful supervision	1	3	4
Physical abuse	2	8	10
Physical neglect	0	2	2
Sexual abuse	0	0	0
Total	**4**	**13**	**17**

Table 3: Interim Meetings Not Conducted and Documented in a Timely Manner

Type of Allegation	Priority 1	Priority 2	Total
Medical neglect	1	0	1
Neglectful supervision	5	7	12
Physical abuse	6	16	22
Physical neglect	0	3	3
Sexual abuse	1	2	3
Total	**13**	**28**	**41**

APPENDIX C: STATE AGENCY COMMENTS

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

COMMISSIONER
H. L. Whitman, Jr.

March 1, 2017

Patricia Wheeler
Regional Inspector General for Audit Services
Health and Human Services/Office of Inspector General
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, Texas 75242

RE: Report Number A-06-15-00049

Dear Ms. Wheeler:

Thank you for providing us a copy of your draft report, and for giving us the opportunity to include comments and our statements of concurrence or nonconcurrence. We appreciated our work with you, and would like to include the following in our response:

1. **Global comment regarding the report title.**

We must politely disagree with your proposed title: *Texas Did Not Always Ensure That Allegations and Referrals of Abuse and Neglect of Children Eligible for Title IV-E Foster Care Payments Were Recorded and Investigated in Accordance with Federal and State Requirements.* This proposed title sensationalizes the underlying findings and misleads readers regarding the true content of the report. First, there was not a single federal requirement at issue. In point of fact, the concerns outlined in the report centered on self-imposed, policy-based state requirements, which the report was unable to successfully link to any actual risks to child safety (see additional discussion of this point below). Second, the title implies that there were weaknesses in the investigations when the contents of the report bear out that the paperwork based requirements with which the report concerned itself were not reflective of an issue with the quality of the investigations themselves. Indeed, the third finding in your report reflects that Texas "did ensure allegations and referrals of abuse and neglect were resolved in accordance

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with state requirements." This additional finding should be reflected in the title along with the items of concern. Texas requests that the title be modified to read as follows: *Texas Ensured Allegations and Referrals of Abuse and Neglect of Children Eligible for Title IV-E Foster Care Payments Were Resolved in Accordance with State Requirements But Did Not Always Ensure Certain State Requirements for Meetings and Timeframes Were Satisfied.*

2. **Conclusion should be accurate.**

As suggested above in the comments regarding the report's title, the summary of the findings in the report should reflect not only the concerns but also the areas in which concerns were not identified. Specifically, while the Report in Brief lists two of the critical findings, the positive finding is simply not listed whatsoever. Similarly, the conclusion on page 6 of the draft report should reflect that 100 percent of the cases reviewed were resolved in accordance with state and federal requirements. In addition, because there is no actual evidence that the paperwork concerns raised by the report presented any actual problems in the investigations, Texas requests that the phrase "and could place foster children at risk" be struck from the first sentence of the conclusion.

3. **Individual responses to recommendations:**

Finding 1: Concur in part

Texas concurs with the finding to the extent that it accurately reflects that 17 out of 100 cases were not submitted to the investigators' supervisors in a timely fashion according to state policy. Texas does not concur with the intimations in the report that this paperwork issue suggests some type of infirmity in the quality of the investigations, as suggested in both the inflammatory title as well as the incomplete conclusion. Of critical importance, as noted in the report, the agency's focus was "performing quality work rather than on completing the investigations in the prescribed timeframe." There is no suggestion that there were any actual problems in the investigations caused by delay in obtaining supervisory approval. While Texas is willing to explore a revision to its policy, the agency's focus will always remain on ensuring that *quality* investigations are being performed within any general parameters for timeliness set by policy.

Finding 2: Concur in part

Texas concurs with the finding to the extent that it accurately reflects that in 41 out of 100 cases an interim meeting with the investigator's supervisor was not conducted or documented as being conducted within 20 days of the report being received by Statewide Intake. Texas does not concur with the intimations in the report that this paperwork issue suggests some type of infirmity in the quality of the investigation. As noted in the report, supervisory review and approval of the cases occurred in all investigations and, more importantly, there is no evidence in

the report that the timeliness issue led to any type of actual risks to child safety. While this is intimated in the conclusion, there is no basis for it. Texas explained initially and reiterates that discussions with supervisors occur throughout the life of the case, and it is misleading to place undue emphasis on the documentation without having evidence that the meetings were not actually taking place.

Finding 3: Concur

We again emphasize our appreciation for this opportunity to provide feedback, and we look forward to working with you in the future.

Sincerely,

H. L. Whitman, Jr.