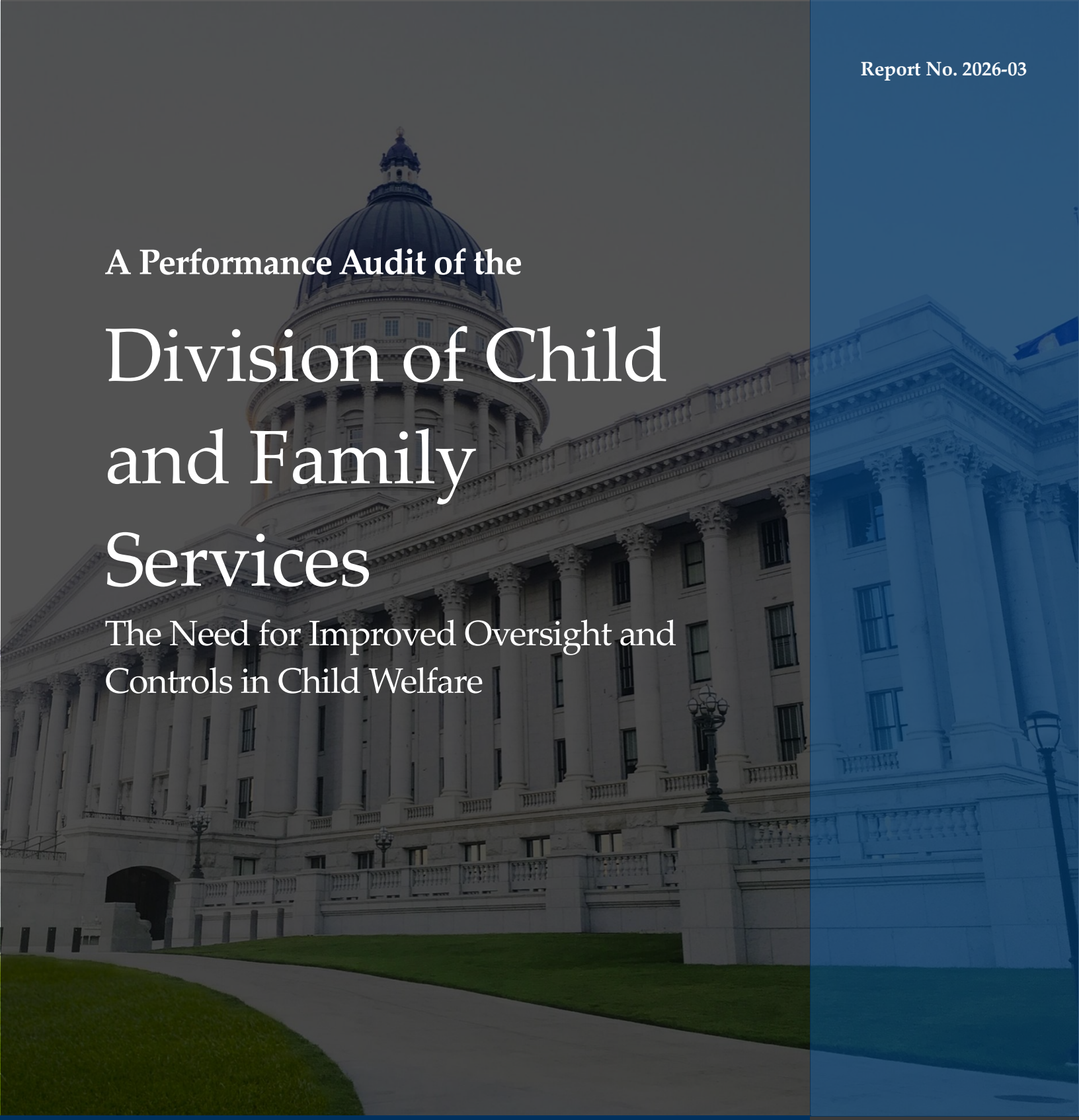
Report No. 2026-03



A Performance Audit of the

Division of Child and Family Services

The Need for Improved Oversight and Controls in Child Welfare

Office of the Legislative Auditor General

Report to the **UTAH LEGISLATURE**

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January 30, 2026

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report:

A Performance Audit of the Division of Child and Family Services [Report #2026-03].

An audit summary is found at the front of the report. The scope and objectives of the audit are included in the audit summary. In addition, each chapter has a corresponding chapter summary found at its beginning.

Utah Code 36-12-15.3(2) requires the Office of the Legislative Auditor General to designate an audited entity's chief officer. Therefore, the designated chief officer for the Department of Health and Human Services is Tracy Gruber. Tracy has been notified that she must comply with the audit response and reporting requirements as outlined in this section of ***Utah Code***.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

Kade Minchey

Kade R. Minchey, CIA, CFE

Auditor General

kminchey@le.utah.gov

LEGISLATIVE AUDITOR GENERAL

AUDIT SUMMARY

REPORT 2026-03 | JANUARY 2026

Office of the Legislative Auditor General | Kade R. Minchey, Auditor General

PERFORMANCE AUDIT

DIVISION OF CHILD AND FAMILY SERVICES

AUDIT REQUEST

Our office was asked to assess how well the Division of Child and Family Services (DCFS) is accomplishing its mission to keep children safe and strengthen families.

In addition to reviewing and analyzing thousands of cases, we also spent time visiting families with caseworkers to observe and better understand DCFS investigations and processes.

BACKGROUND

The Division of Child and Family Services is responsible for investigating allegations of child abuse and neglect.

This audit primarily focuses on investigations conducted by the division's Child Protective Services program and includes recommendations to address both cultural and practice deficiencies that negatively impact child safety.

KEY FINDINGS

- 1.1 Leadership in DCFS and DHHS must set clear objectives and risk tolerances then manage to them.
- 2.1 Children face danger when DCFS investigators neglect investigation policy requirements
- 3.1 OSR Fatality Review reports do not provide the information required by statute.
- 3.2 Fatality Review reports have evolved over time, providing less useful information for the Legislature and DHHS

KEY RECOMMENDATIONS

- 1.1 Senior leadership at DCFS should define objectives and performance targets for Child Protective Services investigation caseworkers and supervisors, along with clear procedures for what must happen when staff fall below those targets. The success of the performance targets will be measured through improved outcomes for children and families.
- 2.1 Supervisors over Child Protective Services teams, including child welfare administrators, should hold their caseworkers accountable to requirements in the DCFS practice guidelines to improve child safety.
- 2.2 Higher levels of management within the Division of Child and Family Services should set a stronger tone at the top, embracing and modeling a culture of control in which high-quality work is expected and low-quality work is routinely identified and corrected.
- 3.1: Fatality committees and the Office of Service Review should provide clear and direct feedback in response to the mandate in *Utah Code* 26B-1-505(6) for committees to render advisory opinions on the series of case review questions listed there.

Senior leadership in DCFS and DHHS must set objectives and risk tolerances then manage to them.

Although most CPS investigations in Fiscal Year 2025 were done correctly, there were nevertheless thousands of cases in which CPS caseworkers missed critical deadlines to see children face-to-face or did not complete statutorily required safety assessments on time. There were also thousands of cases in which supervisors failed to properly oversee their teams' investigations. These are more than simple policy violations; neglecting these key case tools and controls can and has put children in danger.

Further, we found that these practices vary widely across the state, which shows that state-level oversight is weak and needs improvement. The root cause of the troubling variation in performance is a lack of proper management control from the top levels of DCFS leadership down to front-line caseworkers. This has created a culture in CPS in which poor performance is tolerated far too often.

Children face danger when DCFS investigators neglect investigation policy requirements

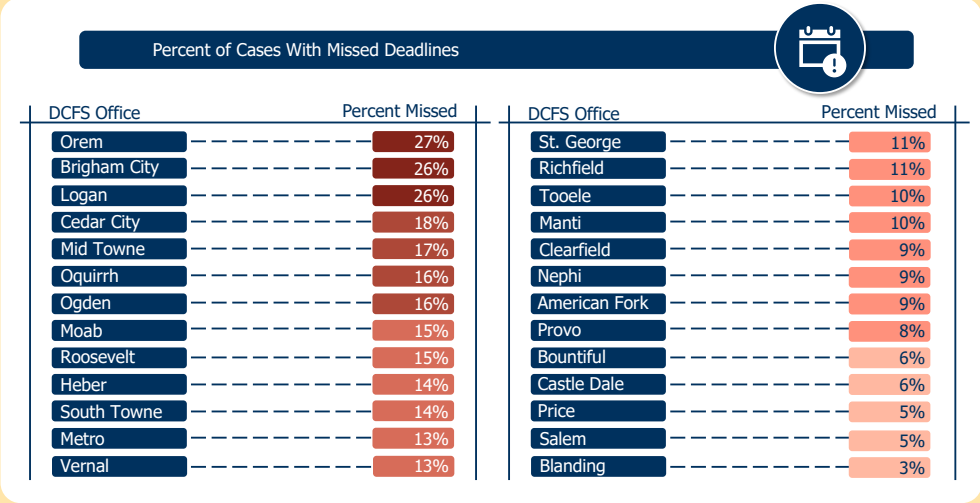
There are concerning patterns in a significant number of cases in which caseworkers violate key investigation policies, leading to less safe conditions for children and unfair actions against families. The cases in which investigators fail to meet policy standards pose an unacceptably high risk to the children the division is meant to protect.

The Lack of Adequate Information in DHHS Fatality Review Reports Limits Oversight of DCFS Child Welfare Activities

The Office of Service Review (OSR) fatality review process has not provided adequate information about the Division of Child and Family Services (DCFS) activities in its reports. This has limited the ability of the Legislature and the Department of Health and Human Services (DHHS) to oversee DCFS activities and the ability of DCFS leaders to identify and correct systemic problems.

In Fiscal Year 2025, CPS Caseworkers Missed the Priority Deadline for Face-to-Face Child Contact on Just Over 3,200 Cases.

Depending on the severity of an allegation, CPS investigators must see children within specific deadlines. We found that CPS offices varied significantly in how well they met these deadlines in Fiscal Year 2025.



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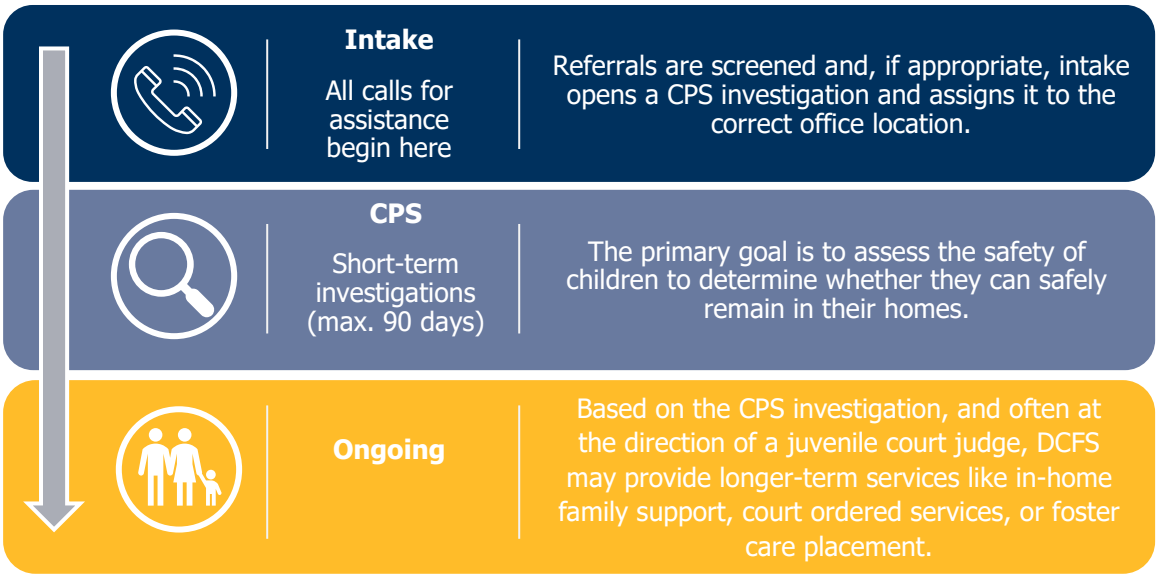
Introduction

It is the public policy of Utah that children have the right to be protected from abuse and neglect. The state therefore has a compelling interest to investigate, prosecute, and punish child abuse and neglect.[1] Protecting children in this way is one of the key roles of the Division of Child and Family Services (DCFS or the division) and is the subject of this audit report.

The Legislature asked our office to assess how DCFS operations keep at-risk children safe. Although the cases DCFS deals with can be nuanced and complex, the services the division provides can be shown in very simple terms.



Source: DCFS

Because the division's most urgent and impactful decisions about child safety are made during Child Protective Services (CPS) investigations, we chose to focus our audit work there. That is not to say that the division's intake and ongoing functions are less important. We simply wanted to review the CPS function as thoroughly as we could on a reasonable timeline.

This report details our findings as follows:

- Chapter 1 discusses significant shortcomings in core safety practices within CPS investigations and how state leadership must take proper control over critical division objectives.

[1] ***Utah Code*** 80-2a-201(2)

- Chapter 2 highlights additional instances of poor CPS investigations and emphasizes the crucial role of regional and local supervision in protecting vulnerable children.
- Chapter 3 then concludes with our findings about the DHHS fatality review process. We believe that those charged with oversight of Utah's child welfare activities should receive much better information from the fatality review reports they receive.

Chapter 1 DCFS Leadership Does Not Exercise Proper Control Over CPS Investigations

BACKGROUND

To protect children, the Division of Child and Family Services (DCFS or the division) investigates allegations of abuse and neglect. Our analysis of three critical performance indicators for Child Protective Services (CPS) investigations reveals significant and troubling variation in how DCFS conducts CPS investigations throughout the state.

Although most CPS investigations in Fiscal Year 2025 were done correctly, there were nevertheless thousands of cases in which CPS caseworkers missed critical deadlines to see children face-to-face or did not complete statutorily required safety assessments on time. There were also thousands of cases in which supervisors failed to properly oversee their teams' investigations.

FINDING 1.1
Leadership in DCFS and DHHS Must Set Clear Objectives and Risk Tolerances Then Manage to Them

RECOMMENDATION 1.1
Senior leadership at the Division of Child and Family Services should define objectives and performance targets for Child Protective Services investigation caseworkers and supervisors, along with clear procedures for what must happen when staff fall below those targets. The success of the performance targets will be measured through improved outcomes for children and families.

RECOMMENDATION 1.2
Once the Division of Child and Family Services has established its key objectives, activities, and performance targets, senior leadership should create data tools that must be used throughout the organization to help ensure that staff are performing as expected.

CONCLUSION

Our analysis of three critical performance indicators for Child Protective Services (CPS) investigations reveals significant and troubling variation in how DCFS conducts CPS investigations throughout the state. In fiscal year 2025, there were thousands of cases in which CPS caseworkers missed critical deadlines to see children face-to-face or did not complete statutorily required safety assessments on time. A lack of proper management control from the top levels of DCFS leadership down to front-line caseworkers has led to weak oversight.

Chapter 1
DCFS Leadership Does Not Exercise Proper Control Over CPS Investigations

To protect children, the Division of Child and Family Services (DCFS or the division) investigates allegations of abuse and neglect. Our analysis of three critical performance indicators for Child Protective Services (CPS) investigations reveals significant and troubling variation in how DCFS conducts CPS investigations throughout the state.

Although most CPS investigations in Fiscal Year 2025 were done correctly, there were nevertheless thousands of cases in which CPS caseworkers missed critical deadlines to see children face-to-face or did not complete statutorily required safety assessments on time. There were also thousands of cases in which supervisors failed to properly oversee their teams' investigations. These are more than simple policy violations; neglecting these key case tools and controls can and has put children in danger. DCFS does valuable, important work and many CPS investigations comply with key policies. But there are far too many cases, in our view, where that has not been the case.

Further, we found that these practices vary widely across the state, which shows that state-level oversight is weak and needs improvement. The root cause of the troubling variation in performance is a lack of proper management control from the top levels of DCFS leadership down to front-line caseworkers. This has created a culture in CPS in which poor performance is tolerated far too often. In addition, the serious CPS deficiencies identified throughout this report reflect an urgent need for better training about the essential principles of child safety, recognizing threats to safety, and understanding risk. Enhanced training in these core areas will help ensure that all personnel are fully equipped to protect the well-being of vulnerable children.

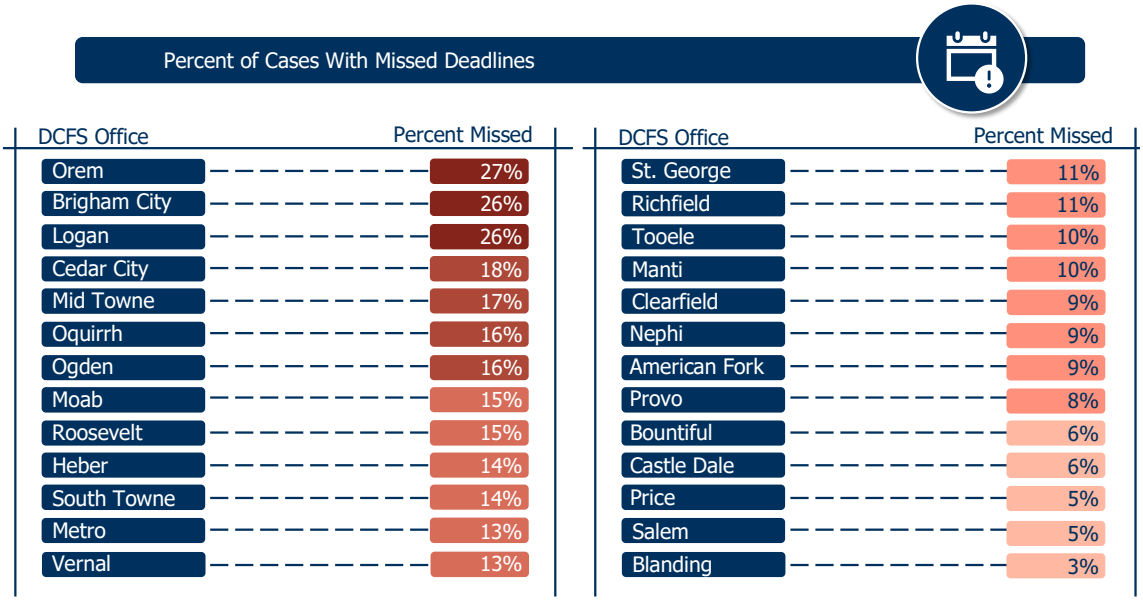
Inconsistent practices across the state reflect insufficient oversight and lack of strong management controls.

1.1 Leadership in DCFS and DHHS Must Set Clear Objectives and Risk Tolerances Then Manage to Them

CPS investigation policies require caseworkers to see a child face-to-face within specific deadlines called priority timeframes. Based on the nature and severity of an allegation, each case is assigned a deadline of either 1 hour, 24 hours, or 3 business days—referred to as priority 1, 2, and 3, respectively. We analyzed how well all CPS offices in the state met these deadlines in Fiscal Year 2025.

The analysis reveals significant variation across offices: those missing the most deadlines do so in over 25 percent of cases, while the best performing offices miss 5 percent or fewer. The results for all 26 CPS offices are shown here.

Figure 1.1 In Fiscal Year 2025, CPS Caseworkers Missed the Priority Deadline for Face-to-Face Child Contact on Just Over 3,200 Cases. The wide variation in how well each office did shows obvious opportunities for improvement.



Source: Auditor analysis of DCFS case data. Total percentage of deadlines missed statewide, 13.7%. Median office performance, 12%.
More detail about the total number of cases per office that were affected by these shortcomings is shown in Appendix A.

The results of this analysis demonstrate some key ideas. First, the wide variation in performance clearly shows that better results are possible. Improving just the top 5 worst-performing offices to the median level of performance (12 percent) would have positively impacted about 490 cases in FY2025.

Improving just the top 5 worst performing offices would positively impact hundreds of cases per year, each of which represents a child or children who may need urgent help.

Second, each one of these cases represents a child or children who may need urgent help. For example, we reviewed the case with the longest missed deadline in Figure 1.1. We found that the caseworker waited for more than three months to respond to the first report about child endangerment and only acted after two more urgent reports came in about a severe injury to one of the children and a newborn that had tested positive for methamphetamine.[2] The subsequent casework progressed well for about one

[2] The worker on this case inaccurately filled out the safety assessment, stating that the newborn had not been exposed to methamphetamine prior to being born. We discuss the critical need to correctly identify and manage children's safety in Chapter 2 of this report.

week, then the caseworker did no documented work until six months later when another referral came in. As the case continued to languish, one child was severely injured and exposed to illegal drugs. The injuries to the child were so severe that we believe the case should have been reported to the Office of Service Review for a near fatality review under the process in ***Utah Code*** 26B-1, Part 5, but it never was.[3] The details above represent gross oversights on the part of the division. All aspects of performance in this case are unacceptable; senior management must immediately take ownership of what amounts to a deep cultural problem in DCFS and take concrete steps to fix it.

As shown here and with other case examples we describe in this report, if workers don't prioritize safety by promptly identifying and responding to a threat, they are far more likely to fail to protect an at-risk child. We believe the range of poor outcomes we found in our case review reflects a clear need to improve DCFS staff training regarding safety and threat assessment so workers can better recognize problems and respond correctly. Chapter 2 in this report will discuss this concept in greater detail.

Finally, we note that the type of analysis shown in Figure 1.1 can clearly show a management team where to direct improvement efforts to have the biggest impact. As indicated by the case we just described, using data in this way can help management identify workers and teams who may urgently need support or correction. For example, Figure 1.1 shows that the Orem office missed the priority deadline in 27 percent of its cases. Using the data, we can see that all but 5 of the 149 missed deadlines in the Orem office were attributable to just two supervisors.

We have repeatedly found that the types of performance numbers shown in Figure 1.1 serve as strong indicators of poor supervision and investigative work that senior leadership must take responsibility for.

We have repeatedly found that the types of numbers shown in Figure 1.1 serve as strong indicators of poor supervision and investigative work that senior leadership must take responsibility for. In addition to what senior management must do, Chapter 2 discusses the key role middle management must play in improving CPS investigations.

Statutorily Required Safety Assessments Were Not Timely For More Than 7,800 Cases in Fiscal Year 2025

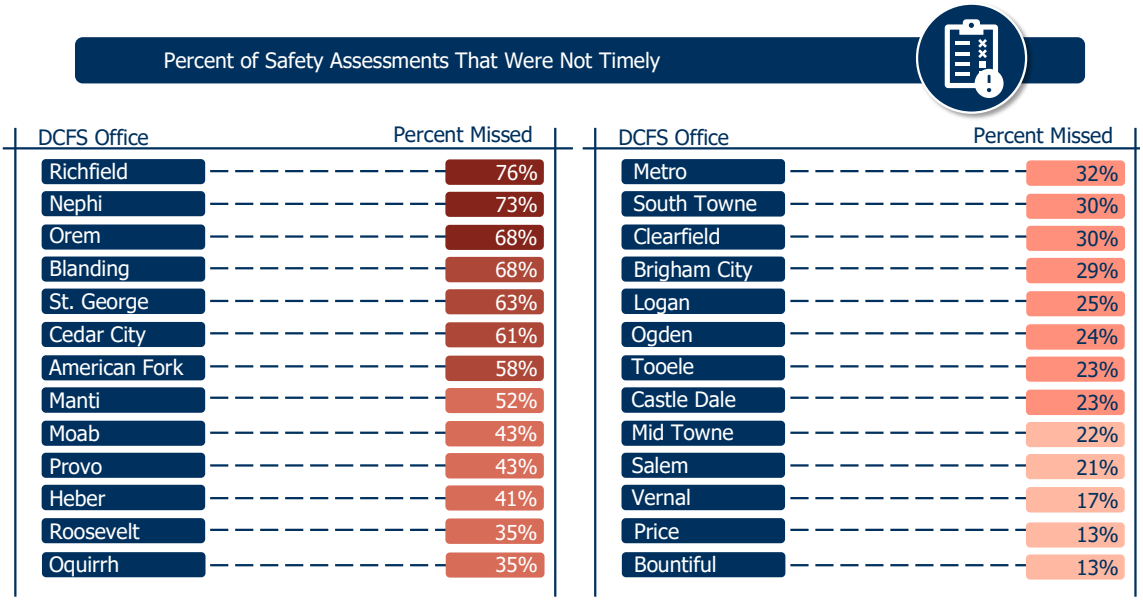
Caseworkers use a statutorily required safety assessment tool to determine whether a child is safe or unsafe. The assessment includes ten structured

[3] For an extensive discussion of this fatality review process, see Chapter 3 of this report.

questions that allow workers to sort their evidence into specific, safety related categories. The output of the assessment provides critical guidance as workers decide whether and how to intervene.[4]

We measured how often CPS caseworkers completed and uploaded safety assessments on time in Fiscal Year 2025. Compared to the last figure, there is a much larger variation in how well different CPS offices satisfied this requirement.

Figure 1.2 In Fiscal Year 2025, Caseworkers Either Did Not Complete or Properly Document Statutorily a Required Safety Assessment in a Timely Manner for More Than 7,800 Cases. These assessments are the primary tool CPS has to make evidence-based decisions about child safety. This must improve.



Source: Auditor analysis of DCFS case data.
More detail is shown in Appendix A about the total number of cases per office that were affected by these shortcomings.

In our case review, we found stark examples of the impact that can occur when safety assessments are not completed promptly or accurately.

[4] ***Utah Code*** 80-2-403 requires evidence-informed or evidence-based safety and risk assessments.

Safety assessment not properly completed, leaving child at risk	
Safety assessment delayed	The caseworker did not complete the SDM safety assessment until more than a month after the child was seen.
Safety assessment improperly completed	The caseworker never contacted the alleged perpetrator or visited the home where the alleged incident occurred—two important elements of an accurate assessment.
Poor investigative work	Additional allegations arose that were not added to the case or investigated by the worker.
Poor supervision	Despite the case languishing for weeks at a time with no meaningful casework occurring, the supervisor made virtually no correction.
Conclusion	We are extremely concerned with the caseworker's lack of effort and the complete lack of supervision.

Neither the safety assessment nor the safety plan were properly completed, leaving child at risk	
Poor investigative work	On two separate occasions, the caseworker had photo evidence of bruising on the child. Despite this, they did not consult medical personnel until months after the first incident and weeks after the second incident.
Safety assessment delayed	The caseworker did not complete the safety assessment until approximately 10 months after the child was first seen. Had it been completed in a timely manner, it may have resulted in the agency taking action and intervening to protect the child.
No formal safety plan completed	The caseworker also failed to put a formal safety plan in place, leading to confusion among law enforcement and other DCFS caseworkers involved with the case.
Conclusion	There were no documented repercussions for either the poor casework or the nearly complete lack of supervision. We are extremely concerned with the caseworker's lack of effort and the nearly complete lack of supervision.

Given the high stakes of CPS investigations, DCFS leadership must act decisively to address poor performance and implement necessary organizational changes.

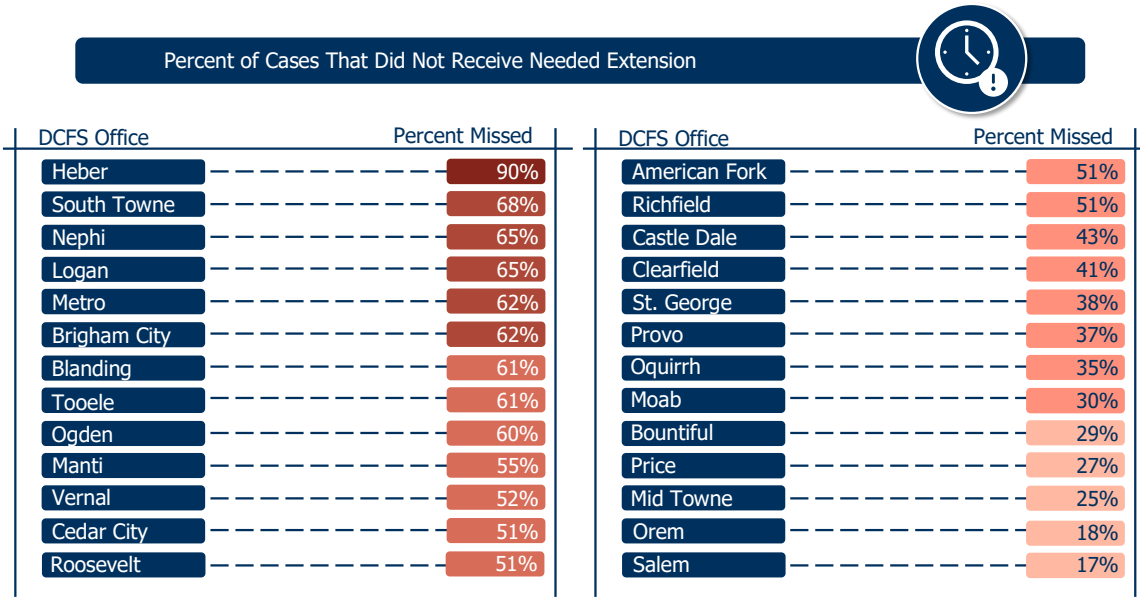
The performance numbers shown in Figure 1.2 illustrate a wide range in how well different offices complete safety assessments. As we did with the data in Figure 1.1, we dug deeper and saw a similar pattern of outlier caseworkers and supervisors who management—both at the top of the organization and in local offices—must support or correct so that they can improve their performance. Considering how high the stakes can be for CPS investigations, senior management for DCFS must make the necessary organizational changes to improve this poor performance.

Many Cases Are Not Closed According to Policy Timelines Due to Poor Casework and Supervision

There are many CPS investigations that last longer than 30 days. CPS supervisors are supposed to review all these cases and grant a timeline extension when more investigative work is needed. We observed many cases that passed the 30-day deadline but did not receive proper case extensions. This shows that the supervisors are not providing adequate oversight, resulting in multiple cases where children were left in dangerous situations.

The numbers shown in Figure 1.3 highlight another area in need of urgent improvement.

Figure 1.3 Among Cases that Closed in Fiscal Year 2025, CPS Supervisors Failed to Approve Needed Extensions for More Than 4,600 Cases. A failure to issue case extensions is a strong indicator that supervisors are not paying attention to their teams' cases. This can increase the risk of harm to children who rely on the division for ongoing protection during investigations.



Source: Auditor analysis of DCFS case data.
More detail about the total number of cases per office that were affected by these shortcomings is shown in Appendix A.

We reviewed some of the cases that were missing proper extensions and found examples of incredibly poor casework.

Year-long investigation and poor oversight endangered child's safety	
No case extensions	This case was open for nearly a year. This is well outside acceptable standards.
Poor investigative work	The caseworker wasted months of time investigating an allegation that had already been fully investigated in a prior case. Additionally, a new allegation came in that the child had been sexually assaulted and taken by unnamed persons. Despite the severity of the allegation, there is no documented action by the caseworker. Instead, another caseworker was assigned eight days later to investigate after it appeared the child was missing.
Poor supervision	The supervisor provided almost no meaningful support or accountability as the investigation languished.
Conclusion	The child's safety was put at risk multiple times and neither the caseworker nor the supervisor appears to have faced any consequences for their poor performance.

Urgent cases assigned to one caseworker received almost no action, with no sign of supervisor involvement	
No work, no oversight	A caseworker was assigned two cases in 2025, one of which was an urgent physical abuse case. As of December 2025, no work had been recorded in either case file, and the cases were still open.
No work, no oversight	On another case, the only work documented from the time the case was opened in June to the date we first reviewed the case was one phone call was made six days after the case began. The case was still open as of December 2025.
Conclusion	We are extremely concerned with the caseworker's lack of effort and the complete lack of supervision.

We pulled documentation for several more cases and found situations where workers let cases languish for weeks or months—hardly doing any investigative work—and supervisors were not engaged enough to identify or correct the problems. Given what we saw in our review of these overdue cases, we believe that the division should use this data to find staff and supervisors in the division who may urgently need support and correction.

We found several situations where workers let cases languish for weeks or months—hardly doing any investigative work—and supervisors were not engaged enough to identify or correct the problems.

DCFS must correct these problems to better serve the children and families under its care.

For Years, DCFS Leadership Has Not Provided Adequate State-Level Oversight

Although DCFS handles many CPS investigations properly, the data in this chapter shows a significant number of uncontrolled cases that pose serious risks to the children and families that DCFS is meant to protect.

This is not the first time our office has been critical of the lack of effective senior-level oversight at DCFS. In 2011, our audit report stated:

Audit 2011–02, A Performance Audit of DCFS

"While there is a state administrative office, there is a lack of centralized administrative oversight which leads to a lack of consistent practice statewide and too much autonomy allowed to regional administration….Though each chapter explains why problems occur, the lack of centralized administrative oversight or enforcement is a root cause."

Based on the results of our current audit (shown both here and in the next chapter) we reaffirm this position taken by our office 15 years ago. We believe that both statewide and regional leadership in DCFS have not built an adequate system of oversight and accountability.

In the case files discussed in this chapter, from offices across the state, we repeatedly see evidence of poor case work that faces no meaningful correction, if it faces correction at all. In the most extreme cases, children faced a legitimate risk of severe injury or death due to the inaction of CPS caseworkers and their supervisors.

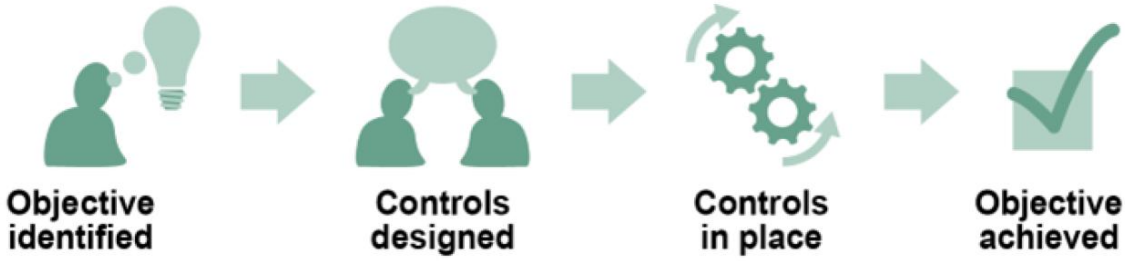
Repeatedly in case files from offices across the state, we see evidence of poor case work that faces no meaningful correction, if it faces correction at all.

The GAO Green Book Provides a Robust Framework for Effective Internal Control

The U.S. Government Accountability Office (GAO) Green Book[5] discusses the concept of internal control at length. The Green Book provides a framework and specific guidance for organizations to build a strong and effective internal control environment. According to the Green Book,

> *Internal control is a process effected by an entity's oversight body, management, and other personnel, designed to provide* ***reasonable assurance that the objectives of an entity will be achieved.***[6] *(emphasis added)*

This is a simplified visualization directly out of the Green Book showing how an effective control environment can lead to desired outcomes:



Source: Government Accountability Office, Standards for Internal Control in the Federal Government

To enhance the control environment and reduce risk within CPS, DCFS senior leadership must begin by establishing clear objectives, defining risks, and setting

[5] Government Accountability Office, *Standards for Internal Control in the Federal Government*, more commonly known as the Green Book.

[6] Green Book, OV1.01

risk tolerances. For CPS, statute states that the primary objective of an investigation is to protect the children involved.[7]

Management should articulate specific performance goals or thresholds for key elements of CPS operations and explicitly identify the types and levels of risk the division is willing to accept in pursuit of those targets. The Green Book says,

> *Management defines risk tolerances for the defined objectives. Risk tolerance is the acceptable level of variation in performance relative to the achievement of objectives.*[8]

To enhance the control environment and reduce risk within CPS, DCFS senior leadership must begin by establishing clear objectives, defining risks, and setting risk tolerances.

By setting these boundaries, senior leadership will provide regional leadership with the clarity needed to prioritize their actions and allocate personnel and time more effectively. This process could consist of senior division leadership setting specific performance targets then defining what must happen when staff fall below those targets. In our review, we found no clear performance targets currently in place to regularly evaluate the actions of specific CPS employees or supervisors.

RECOMMENDATION 1.1

Senior leadership at the Division of Child and Family Services should define objectives and performance targets for Child Protective Services investigation caseworkers and supervisors, along with clear procedures for what must happen when staff fall below those targets. The success of the performance targets will be measured through improved outcomes for children and families.

Monitoring and Enforcement Activities Are Necessary to Unite All Levels of the Organization Around Leadership's Standards

In simple terms, management should identify an organization's key objectives and design the organizational structure and control activities needed to reasonably accomplish those objectives. Staff then implement the control activities. Internal control should not be thought of as a separate system within an agency. Instead, it is an integral idea that is reflected in both the design and the execution of the organization's structure, policies, procedures, and day-to-day activities.

[7] ***Utah Code*** 80-2-701(1), 80-2a-201(2)

[8] Green Book, 6.08

DCFS has robust CPS investigation policies that appear to be clear and commonly understood, even if they are not always followed. We believe that these policies set good practical expectations for caseworkers and we see them as a strength for the division.

The extensive internal data available to DCFS is a significant asset, positioning the agency to effectively implement the improvements discussed in this chapter. The Green Book[9] says,

"Management should obtain or generate relevant, quality information and use it to support the functioning of the internal control system."

GAO Green Book

"Ongoing monitoring is built into the entity's operations, performed continually, and responsive to change."

"Management should obtain or generate relevant, quality information and use it to support the functioning of the internal control system."

Currently, the division is transitioning between data systems, inhibiting the division from adequately leveraging performance information. Once the division has established its key objectives, activities, and performance targets, it should create data tools that can be used throughout the organization to help ensure that staff are performing as expected. As an audit team, we took this approach and found it to be very effective at finding teams and caseworkers in need of support. We believe division leadership will have the same experience.

RECOMMENDATION 1.2

Once the Division of Child and Family Services has established its key objectives, activities, and performance targets, senior leadership should create data tools that must be used throughout the organization to help ensure that staff are performing as expected.

There are additional improvements related to enforcement that are needed at the local management level. Those improvements are discussed in Chapter 2 of this report.

[9] Green Book, Principle 13 and Principle 16

Chapter 2 DCFS Investigation Shortcomings Can Put Children at Risk; Strengthening Supervision Is Critical

BACKGROUND

To protect children, the Division of Child and Family Services (DCFS) investigates allegations of abuse and neglect. The division has a robust set of policies—referred to as practice guidelines—to help ensure that caseworkers have the greatest chance of success. DCFS caseworkers follow key investigation policies in a majority of their approximately 22,000 cases per year.

FINDING 2.1
Children Face Danger When DCFS Investigators Neglect Investigation Policy Requirements

RECOMMENDATION 2.1
Supervisors over Child Protective Services teams, including child welfare administrators, should hold their caseworkers accountable to requirements in the DCFS practice guidelines to improve child safety.

RECOMMENDATION 2.2
Higher levels of management within the Division of Child and Family Services should set a stronger tone at the top, embracing and modeling a culture of control in which high quality work is expected and low quality work is routinely identified and corrected.

CONCLUSION

There are concerning patterns in a significant number of cases in which caseworkers violate key investigation policies, leading to less safe conditions for children and unfair actions against families. The cases in which investigators fail to meet policy standards pose an unacceptably high risk to the children the division is meant to protect. The division must elevate its standard for child welfare investigations both in local DCFS offices around the state and at the level of division leadership.

Chapter 2
DCFS Investigation Shortcomings Can Put Children at Risk; Strengthening Supervision Is Critical

To protect children, the Division of Child and Family Services (DCFS or the division) investigates allegations of abuse and neglect. The division has a robust set of policies—referred to as practice guidelines—to help ensure that caseworkers have the greatest chance of success.[10]

DCFS caseworkers follow essential investigation policies in most of the more than 23,000 Child Protective Services (CPS) cases they handle each year.

Caseworkers are neglecting key policy requirements in a relatively small but significant number of investigations.

However, there are concerning patterns in a significant number of cases in which caseworkers violate key investigation policies, potentially leading to less safe conditions for children and unfair actions against families. The cases in which investigators fail to meet policy standards pose an unacceptable risk to the children the division is meant to protect.

The division must elevate its standard for child welfare investigations both in local DCFS offices around the state and at the level of division leadership. This chapter discusses how the division's existing supervision structure should be better used to ensure that cases are worked according to best practices and children are made as safe as possible during agency interventions. Chapter 1 focuses on how the division's upper leadership level can better use performance data and targets to help staff improve across the state.

2.1 Children May Face Danger When DCFS Investigators Neglect Investigation Policy Requirements

Our audit team reviewed just over 160 CPS investigation case files, in addition to our data analysis shown in Chapter 1 of this report. We found examples of good casework where children were made safer and families were made stronger. We also reviewed cases in which caseworkers neglected key procedures related to safety assessment and planning and, in our view, exposed the children in those cases to undue and

Children were exposed to undue and avoidable risk in some of the cases we reviewed for this audit.

[10] These professional standards for investigations are required by ***Utah Code*** 80-2-701(2) and a non-exhaustive list of requirements for these standards is given in ***Utah Code*** 80-2-702(2).

avoidable risk. We believe that the problems we saw are significant enough that leadership at all levels of the division must take steps to improve both the quality and accountability of its investigation work.

When Threats Against Child Safety Are Not Properly Identified and Managed, Risk Increases

The primary purpose of CPS investigations is to protect the children involved, keeping them in the home whenever possible.[11] These investigations are short-term efforts—typically 30 days, or up to 90 days with proper case extensions—designed to assess whether a child can safely remain in his or her home. Assessing and managing child safety are the most important aspects of any DCFS investigation. For this reason, the division has multiple specific requirements and tools meant to help identify and mitigate threats to safety that arise during their investigations.

Our audit team reviewed just over 160 DCFS cases and found multiple instances in which child safety did not appear to be at the forefront of the caseworker's actions. For example, in one of the cases we reviewed, the division received a report of a severely injured child. Multiple investigation policies related to safety assessment and planning were violated. Our review of that case found the following:

Assessing and managing child safety are the most important aspects of any DCFS investigation.

[11] ***Utah Code*** 80-2-306(1), 80-2-701(1), 80-2a-201(2)

Child in grave danger was left in harm's way repeatedly	
Safety plan inadequate	The caseworker created a short-term safety plan[12] with the caregiver but failed to properly identify threats to the child's safety.
Child left in danger	A medical professional completed an exam and found that the child was "at high risk of further injury or death" if placed back with the individual(s) who caused the injuries. The child remained with the caregiver despite the caregiver's refusal to cooperate with the investigation, and the safety plan expired. Despite the dire warning from the medical professional, the caregiver's refusal to participate in the investigation, and a direct request from the caseworker's supervisor to do so, the caseworker never created a new safety plan.[13]
Safety assessment was delayed	The statutorily required safety assessment inaccurately reflected the caregiver's willingness to cooperate. This made the child look safer than they actually were.
Child left in danger again	Weeks passed and additional reports of abuse came into the division. The child was severely injured again. DCFS investigators visited the child, photographed the injuries, and left. No new safety assessment or safety plan was completed at that time.
Child made safe	Soon after, the child was finally made safe through law enforcement actions.
Conclusion	The repeated failure to assess and manage safety in accordance with DCFS tool and policy left this child in a very dangerous situation for weeks, resulting in additional injuries.

As we reviewed cases from older fatality review reports—a topic we discuss in Chapter 3 of this report—we observed another case from 2017 that was strikingly similar to the one we just described. In that case, the safety assessment was not completed until after the child's death, the caseworker did not seek proper medical or legal support, and the child was left in the home despite the

[12] A safety plan is a tool used by DCFS investigators to partner with willing and able caregivers to identify threats to a child's safety, decide how to mitigate those threats, and assign specific relevant action steps to specific individuals for a set amount of time. For example, if the uncle is the alleged abuser, the plan could be for the mother and father to keep the child away from the uncle or ensure the child is supervised when he or she is around the uncle.

[13] A law enforcement investigation was happening in parallel with this DCFS investigation. In these cases, ***Utah Code*** 80-2-701(8) states that the division shall coordinate with law enforcement to ensure that there is an adequate safety plan in place to protect the child from further harm.

caseworker observing terrible injuries. It is highly concerning that similar, inexcusably bad situations are still occurring eight years later.

We observed other cases where DCFS did not properly identify and manage threats to safety, increasing risk for the children involved.

Meth-exposed newborn left at risk while safety plan was ignored	
Safety plan with no action	A newborn baby tested positive for methamphetamine due to the mother's drug use. The caseworker's safety plan required the mother to undergo drug testing during the investigation, but no test results were ever documented, and the child remained with the mother as the investigation stalled for weeks.
Inadequate documentation	Although the baby's umbilical cord had tested positive for methamphetamine just three days after the investigation began, those results were not uploaded to the case file for three months and not mentioned in case notes for another two weeks after that.
Conclusion	By neglecting the safety plan and failing to investigate the case appropriately, the child was exposed to undue risk for far too long.

Deficient safety and risk assessments	
Risk assessment without enough information	In another case, the caseworker did not complete a safety assessment despite reports of physical abuse. The caseworker completed a risk assessment without seeing the child face-to-face or completing a visit to the family's home.[14] Without having completed those required investigation steps, the worker lacked the required information to fill out the assessment correctly.
Conclusion	Through these actions, the caseworker did not adequately assess or manage the child's safety.

[14] A risk assessment is similar to a safety assessment. While a safety assessment is meant to identify immediately threats to a child's safety, a risk assessment is meant to identify the likelihood that a child will experience abuse or neglect in the next 12–18 months.

These cases demonstrate that overlooking key safety tools and policies can lead to situations where caseworkers are not adequately assessing or managing children's safety. These cases also highlight a critical need to improve staff knowledge of fundamental concepts of child safety, how to identify potential safety threats, and how to accurately assess risk factors. Strengthening training in these vital areas could better prepare personnel to fulfill the division's responsibility of safeguarding vulnerable children.

Overlooking key safety tools and policies can lead to situations where caseworkers are not adequately assessing or managing children's safety.

There are other situations where the policy violations were less extreme; however, the children involved were still made less safe due to how important each safety-related policy requirement is and the high stakes that are possible in each DCFS investigation. We did not find evidence of DCFS taking effective steps to hold staff accountable and directly prevent similar problems from happening again. As mentioned in Chapter 1, our 2011 audit of DCFS found that a lack of adequate oversight or enforcement was a root cause of problems identified in that report.

An internal assessment of risk and safety management shows that the cases we reviewed were not isolated instances. An analysis of all CPS investigations that were closed in Fiscal Year 2025 found that caseworkers filed safety assessments late in 33.4 percent of cases.[15] Statistics from a 2018 federal review and a 2025 internal review of Utah cases show that caseworkers completed safety assessments 82 to 85 percent of the time and that caseworkers appropriately developed and monitored safety plans just 50 to 54 percent of the time.[16]

We believe that the risk that children face when caseworkers do not complete safety assessments and plans on time or correctly is far too high. This risk should be addressed by DCFS leadership, as detailed later in this chapter.

[15] This means that the safety assessment was not completed and uploaded to the case documentation system within five business days from the first contact with the child or children. This was true for 7,994 of the 23,919 cases in this data set.

[16] Like other child welfare agencies across the country, DCFS is subject to federal oversight through the Child and Family Services Reviews (CFSR) process administered by the U.S. Department of Health & Human Services. A range of percentages is given here to reflect results from different years. DCFS will undergo another federal CFSR assessment in 2026.

Caseworkers and Supervisors Increase Risk When Alleged Child Victims Are Not Seen Fast Enough

There are thousands of cases each year in which caseworkers do not see children within acceptable timeframes.

The division's practice guidelines (i.e., investigation policies) set out certain specific deadlines. First, the DCFS intake team evaluates the nature and severity of an allegation. The team then assigns a deadline of either 1 hour, 24 hours, or 3 business days—referred to as priority 1, 2, and 3, respectively. Within the assigned deadline, a caseworker must make face-to-face contact with the alleged child victim. As shown in Chapter 1, there were thousands of cases in Fiscal Year 2025 in which caseworkers did not see children within these timeframes. This is very concerning, and DCFS must improve. The following are examples of the consequences of these policies being violated:

- Because of the severity of the injuries in the first case mentioned in this chapter, the caseworker was given 24 hours to see the child face-to-face. The worker missed that deadline.

In Fiscal Year 2025, caseworkers missed priority deadlines in 13.7 percent of cases, totaling over 3,200 instances.

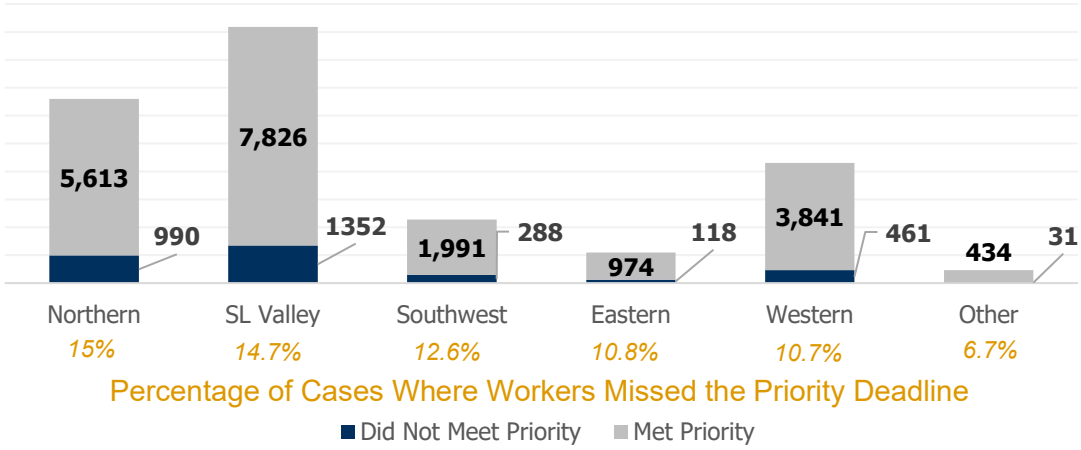
- In another case, also mentioned previously in this chapter, an allegation was made that an adult physically abused a child. The child told individuals what had happened; the individuals, observing physical injuries on the child, called DCFS. The case was given a 24-hour response deadline due to the visible injuries. The caseworker missed this deadline, not seeing the child for nearly a week. The caseworker did not note any visible injuries during the visit. We believe that the delay directly contributed to what may have been a missed opportunity to help the child.[17] Subsequently, it was learned that the child continued to get physically abused.
- In other cases, workers in different offices around the state made initial attempts to contact alleged victims via unannounced home visits or phone calls. Caseworkers let weeks or even months pass by before making another attempt and finally seeing the child face-to-face.

There should be a sense of urgency in responding to allegations of child abuse and neglect. Our analysis of all Fiscal Year 2025 cases found that caseworkers

[17] Further, there was no adequate explanation for the worker's delay in the case activity logs.

missed priority deadlines to see the child in person in 13.7 percent of all cases. This equates to just over 3,200 cases in total.

Figure 2.1 In Fiscal Year 2025, Caseworkers Missed the Priority Deadline on 13.5 Percent of All Cases. Caseworkers missed their priority deadlines in 3,240 out of 23,919 cases.



Source: Auditor analysis of DCFS data.

As discussed in Chapter 1, senior division leadership must work to establish a higher performance standard. As discussed later in this chapter, supervisors must also hold caseworkers to this standard through proper and supportive oversight.

We Observed Two Cases Where Families Were Treated Unfairly by CPS Investigators

There is also a risk of poor investigative work and policy violation leading to the division taking unjustified action against a family. In our review, we saw two such cases.

Caseworker secretly observed family in hospital and unfairly accused them of neglecting their child	
Secret observation	While the child was in the hospital, a caseworker dressed in hospital clothing and entered the hospital room, never speaking with the family. Neither the caseworker nor the doctors told the family there were concerns.
Poor investigation	The caseworker visited the wrong home repeatedly. The family asked for a list of actions they needed to do to comply with the investigation; the caseworker never provided the list.
Family prevailed in a costly court fight	This case went to court, costing the family tens of thousands of dollars in legal fees. The judge ruled in

	favor of the family stating there was inadequate evidence to demonstrate harm to the child.
Division still has findings against the family	Despite the judge determining that the parents had not mistreated the child, division records still show a finding that both parents did so.
No consequences	We believe the facts of the case represent an unfair use of regulatory power by the division. Our review of personnel files found no record of discipline for the caseworker for what happened in this case.

We also observed a case where the division supported a finding of abuse against parents despite having insufficient evidence to do so. When one of the parents challenged the finding, the division overturned it, citing in its records that it lacked adequate evidence to have drawn those conclusions.

These cases demonstrate that poor investigative work and policy violations can also lead to unfair actions against families. This is a misuse of the division's authority, forcing innocent families to spend significant time and money to defend themselves. As with the other poor investigations detailed in this chapter, the root cause is a system in which caseworkers can deviate from good practice and supervisors don't catch or correct the problems.

Supervisors and Senior Leadership Have Created a Culture Where Poor Performance Is Implicitly Allowed

Caseworkers should never feel that critical requirements are optional.

We believe that the direct cause of the shortcomings described in this chapter is an organizational culture in which some caseworkers and supervisors feel it is acceptable to cut corners without meaningful oversight or consequence. Performance statistics that we discussed more in Chapter 1 indicate that this lackluster performance is not found throughout the entire organization. Rather, there are specific offices and teams where a culture of non-compliance has taken root. Leadership can and should take steps to correct culture and help these employees.

For the most concerning cases we reviewed, we interviewed knowledgeable individuals throughout the organization. We also requested personnel records to determine whether the employees in question had received support and/or discipline as appropriate. We believe that the division's response to some of the more egregious examples of case mismanagement fell short of what should have happened to correct problems and improve performance. One caseworker was actually given an above average performance rating during a case in which they

neglected several key policies and the child was put in dangerous situations on multiple occasions.

If certain employees can ignore instructions from supervisors and neglect policy requirements with no reason to believe they will face consequences, it is unsurprising that we have been able to find an unacceptable number of problematic cases during our audit. DCFS does valuable, important work. Many CPS investigations comply with key policies, and many children and families have benefitted from their interactions with the agency. But there are far too many cases, in our view, where that has not been the case. Improvements are needed on behalf of those clients who are not benefiting from the work of higher-performing caseworkers and supervisors.

DCFS has helped many children and families, but too many cases still fall short. Improvements are needed for those not benefiting from higher-performing staff.

All Levels of Management Are Responsible for the Division's Culture and Control Environment

The U.S. Government Accountability Office (GAO) provides excellent guidance regarding proper management and supervision. Broadly speaking, everyone in an organization is responsible for an internal control system designed to provide reasonable assurance that key objectives will be achieved. In CPS investigations, that key objective is child safety.[18]

The GAO Green Book[19] states, "Management—at all levels within the entity's organizational structure…is responsible for an effective internal control system," and that:

GAO Green Book

"Management should evaluate performance and hold individuals accountable for their internal control responsibilities. . . . Accountability for performance of internal control responsibility supports day-to-day decision-making, attitudes, and behaviors."

[18] ***Utah Code*** 80-2-701(1), 80-2a-201(2), (5), (7)

[19] Government Accountability Office, *Standards for Internal Control in the Federal Government*, more commonly known as the Green Book.

In simple terms, management identifies its key objectives and designs the organizational structure and control activities needed to reasonably accomplish those objectives. Staff then implement the control activities. Internal control should not be thought of as a separate system within an agency. Instead, it is an integral idea that is reflected in both the design and the execution of the organization's structure, policies, procedures, and day-to-day activities.

DCFS Leadership Has Created a Culture Where Too Many People Believe That Substandard Work Is Acceptable

The responsibility to create and maintain a culture of control and excellence rests with senior leadership and should be echoed by every other leadership position throughout the organization.

Ultimately, the performance numbers in Chapter 1 and the case examples detailed here lead us to believe that the root cause of poor performance in CPS is cultural. The responsibility to create and maintain a culture of control and excellence rests with senior leadership and should be echoed by every other leadership position throughout the organization. An organization simply cannot thrive when leadership teaches employees by its example that substandard work is acceptable.

We believe that the supervision and policy structure of DCFS is already well suited to the task of improving caseworker performance. The division has broken the state into five regions, each with a region director. Below the region director level, there are intermediary supervisors, known as child welfare administrators (CWAs), who oversee multiple smaller teams. Each smaller team has a supervisor who directly oversees approximately 5–7 employees.[20]

When it comes to policies, the division has a robust set of practice guidelines with clear standards for investigations. While an organization's policies and procedures can always improve, we see no major deficiencies in the practice guidelines that we believe meaningfully contribute to the poor performance identified in this chapter.

[20] The focus of this audit has been solely on the Child Protective Services program within DCFS. There are teams dedicated to other key aspects of DCFS operations—like referral intake, foster care, and transition to adult living—whose work we did not review.

With clearer expectations, improved support, and more effective oversight, CPS team supervisors can have an immediate positive impact on their team members' case performance. In turn, CWAs and the regional leadership teams can provide support and oversight as needed to improve performance across all CPS teams.

RECOMMENDATION 2.1

Supervisors over Child Protective Services teams, including child welfare administrators, should hold their caseworkers accountable to requirements in the DCFS practice guidelines to improve child safety.

In addition to existing practice guidelines, DCFS leadership should also create written performance standards for regional and local supervisors. Specifically, these standards should reference the performance targets discussed in Chapter 1 so that senior management's objectives and risk tolerances are directly linked to the performance of all employees in the division's chain of command. Recommendation 1.1 in Chapter 1 deals directly with this.

These Needed Changes Are Attainable, and The Division Has Already Started

There are real challenges for child welfare workers—both professional and emotional—but we believe that necessary improvements are within reach if supervisors provide their teams with quality, daily oversight. For example, there is evidence in some of the troubling cases we reviewed that supervisors reviewed the case files and logs multiple times and told their caseworkers to, for example, complete a new safety plan or close the case. The only thing lacking in those scenarios was accountability from the supervisor to make sure these requested and critical tasks were completed. This type of oversight and accountability is the primary role of any supervisor.

There are real challenges for child welfare workers, but we believe that necessary improvements are within reach if supervisors provide their teams with quality, daily oversight.

To help supervisors in this role, DCFS has already rolled out a tool across the division often referred to as "data board." A physical board sits in supervisors' offices, and their teams use sticky notes to track each case through its full life cycle during regular team meetings. This is a tangible tool that, if used correctly, can help supervisors oversee and control the cases and caseloads of their team members. If a certain supervisor is struggling, the child welfare administrator (i.e., the supervisor's boss) can mentor that supervisor in

the proper use of a tool like the data board. The child welfare administrator can also provide regular oversight and mentoring to help ensure that the supervisor is improving their performance accordingly. Anecdotally, those teams that have faithfully adopted the data board process have seen significant improvements.

The division has also begun to address the issues we have raised here by implementing a new quality assurance process. It is too early to tell what effect that will have on casework, but both DCFS leadership and employees seem enthusiastic about its potential.

The division has begun to address the issues we have raised here by implementing a new quality assurance process.

In the end, division leadership must decide what tools will best support DCFS investigative work and build a system and culture of strong internal control where all employees understand that high-quality investigative work is necessary to keep children safe.

RECOMMENDATION 2.2

Higher levels of management within the Division of Child and Family Services should set a stronger tone at the top, embracing and modeling a culture of control in which high-quality work is expected and low-quality work is routinely identified and corrected.

Chapter 3 The Lack of Adequate Information in DHHS Fatality Review Reports Limits Oversight of DCFS Child Welfare Activities

BACKGROUND

When a child who is in the custody of DCFS or has recently received services from DCFS dies or nearly dies, the Office of Service Review convenes a committee of experts to issue a fatality review report. The committee reviews the details of the cases related to the child. The main purpose of the report is to communicate to the legislature and DHHS the committee's advisory opinion about key statutory questions.

FINDING 3.1
OSR Fatality Reviews Do Not Provide the Information Required by Statute

RECOMMENDATION 3.1
Fatality committees and the Office of Service Review should provide clear and direct feedback in response to the mandate in Utah Code 26B-1-505(6) for committees to render advisory opinions on the series of case review questions listed there.

RECOMMENDATION 3.2
Administrators over the fatality review process must ensure that, when appropriate, the required response process in statute is executed correctly.

FINDING 3.2
Fatality Review Reports Have Evolved Over Time, Providing Less Useful Information for the Legislature and DHHS

RECOMMENDATION 3.3
The Office of Service Review should improve the readability of the fatality review reports as permitted in statute and requested by members of the Child Welfare Legislative Oversight Panel.

RECOMMENDATION 3.4
In light of the panel's authority to read unredacted child welfare case documents, the Legislature should consider granting unredacted access for fatality review reports to members of the Child Welfare Legislative Oversight Panel.

CONCLUSION

Our analysis of fatality review reports shows troubling deficiencies that starve the oversight process, undermining accountability and contributing to a culture of noncompliance in DCFS. The fatality review reports fail to identify policy violations and do not provide adequate advisory opinions for the case review questions listed in statute.

Chapter 3
The Lack of Adequate Information in DHHS Fatality Review Reports Limits Oversight of DCFS Child Welfare Activities

The Office of Service Review (OSR) fatality review process has not provided adequate information about the Division of Child and Family Services (DCFS) activities in its reports. This has limited the ability of the Legislature and the Department of Health and Human Services (DHHS) to oversee DCFS activities and the ability of DCFS leaders to identify and correct systemic problems.

According to statute, the Child Welfare Legislative Oversight Panel (CWLOP) and other stakeholders in the Legislature are responsible for providing oversight of child welfare throughout the state of Utah.[21] To assist these legislative stakeholders in accomplishing this mission, OSR and other agencies provide reports with information about child welfare in the state. OSR should correct the deficiencies shown in this chapter to better meet statutory requirements and to give more complete information to the Legislature.

3.1 OSR Fatality Review Reports Do Not Provide the Information Required by Statute

The fatality review process was established in statute to support the goals of transparency, accountability, and process improvement. However, recent fatality review reports have fallen short of these goals. We found multiple instances where troubling policy violations went unreported and one report that contained multiple factual errors.

Recent fatality review reports have fallen short of the statute's goals.

A fatality review committee is a panel of experts created by law to review cases where someone has died or nearly died and had recently received services from certain agencies within DHHS.[22] Once a fatality committee completes its work, it writes a report that is sent to multiple stakeholders within both DHHS and the Legislature. The main purpose of the report is to communicate the fatality committee's advisory opinions about four key statutory questions:

[21] ***Utah Code*** 36-33-103; ***Utah Code*** 26B-1-507(1)

[22] See ***Utah Code*** 26B-1, Part 5.

1. Whether the provisions of law, rule, policy, and procedure... were complied with during the agency's interaction with the family

2. Whether the near fatality or the death was responded to properly

3. Whether to recommend that a law, rule, policy, or procedure be changed

4. Whether additional training is needed

Source: ***Utah Code*** *26B-1-505(6)*

The fatality committee is supposed to review and discuss each fatality or near fatality then issue an advisory opinion on each of the four statutory questions in its final report. In response, DHHS leadership should develop a plan of action to implement any recommended improvements, and Legislative stakeholders should determine "whether to recommend a change to the law."[23] Given the scope of this audit, we focused only on the reviews related to DCFS services.

Multiple Fatality Review Reports Claim DCFS Followed Policy Even Though Case Records Show Serious Violations

Over the past eight years, fatality committees have reported fewer and fewer instances of policy violations. In fact, between 2023 and 2025, they did not report any policy violations. We independently reviewed some of those same cases and found multiple significant policy violations that should have been reported.

[23] ***Utah Code*** 26B-1-506(2) and (3); 26B-1-507(2) and (3).

Figure 3.1 Despite a Statutory Requirement to Do So, the Fatality Review Committee Has Stopped Reporting Instances of DCFS Policy Noncompliance. In 2023–2025, fatality review reports showed zero policy violations. We reviewed those cases and found multiple instances of significant policy violations that should have been reported.

	2018	2019	2020	2021	2022	2023	2024	2025
Total Fatality Review Reports	23	45	51	34	41	60	59	27
Reports With Identified Policy Noncompliance	9	20	15	2	1	0	0	0
% of Reports With Identified Policy Noncompliance	39%	44%	29%	6%	2%	0%	0%	0%

Source: Auditor analysis of OSR fatality review reports from 2018 to 2025.

We did an in-depth review of several of the cases from the 2023–2025 period shown in Figure 3.1 to determine whether the committee's assessments were accurate. Our review found instances of significant noncompliance with law, rule, policy, and procedure that, according to statute, should have been reported in those fatality review reports. As discussed in the other chapters of this report, instances of noncompliance with DCFS policies can directly impact child safety.

- In three of the cases reviewed, the caseworker did not complete a timely safety assessment. Two of the assessments were not completed until a week or more after the child was first seen. In the other case, it took more than a month after the child was first seen. According to DCFS Practice Guidelines, the safety assessment must be completed "DURING the first face-to-face contact with the child victim" and be recorded in their case management system by the end of the fifth business day.
- In another case, a child was fetally exposed to drugs, but the caseworker marked "No" on the safety assessment in response to the question of whether a child had been fetally exposed.
- During one investigation, the caseworker never interviewed the alleged perpetrator nor visited the alleged perpetrator's home. DCFS Practice Guidelines state that an "alleged perpetrator will be interviewed by the CPS worker" and that the "visit will occur in the household of the alleged perpetrator."
- A caseworker missed the 24-hour deadline to see a child with visible physical injuries by six days.

Despite these instances of noncompliance—some of which were called out in the text of the fatality review reports themselves—the committee reports stated that policy was followed in every case reviewed over the past three years. As we reviewed older fatality review reports, we saw that former committees appeared to be much more willing to report these types of problems. This is clearly reflected in the numbers in Figure 3.1.

Despite instances of noncompliance, recent fatality review reports stated that policy was followed for all cases.

Leadership in OSR and DCFS explained that the shift in practice happened in response to guidance from consultants. Leaders reported that the fatality review process historically gave harsh critique to individual caseworkers instead of extracting broader lessons for the entire organization. The consultants encouraged the agency to focus on collaborating with the staff involved in the cases to deeply understand the true cause of problems. This deep understanding could then lead to better recommendations.

While this would be a sound approach to continuous improvement if it were implemented correctly, we believe that the fatality review process has not actually implemented the advice the consultants gave. Those involved have simply stopped reporting negative information without engaging in the deeper work and transparency needed to give feedback and impactful recommendations the system clearly needs. The result is a process that has been starved of the very information it was created to produce.

By including incomplete information in the reports, the entire process is frustrated, leaving all stakeholders without enough information to learn and improve. Most importantly, it leaves those with oversight responsibility in both the Legislature and DHHS without adequate information to assess true DCFS performance in these most severe cases.

By including inaccurate or incomplete information in fatality reports, the entire process is frustrated.

One Fatality Review Contained Factual Errors and Failed to Mention Investigation Policy Violations

We reviewed several DCFS cases discussed in fatality review reports. In one of the reports, we found multiple factual errors in the case summaries prepared by OSR staff, such as misrepresenting a caseworker's decision not to interview certain family members and overlooking evidence clearly present in case files. The report also acknowledged a significant policy violation yet ultimately

claimed no violations occurred, failing to accurately answer the statutory question regarding policy compliance.

One fatality review contained factual errors, depriving stakeholders of accurate and useful information.

In addition to the other examples in this chapter in which key information was excluded from the fatality review report, we believe that the individuals in the Legislature and DHHS who read this report did not receive information that was accurate or sufficient to determine if lessons could be learned to improve DCFS operations.

In light of the several examples of violated policies that have gone unreported, the Office of Service Review and the fatality committees that review these cases should better adhere to statute by identifying and reporting all instances of law, rule, policy, and procedure violations in all fatality review reports.

RECOMMENDATION 3.1

Fatality committees and the Office of Service Review should provide clear and direct feedback in response to the mandate in ***Utah Code*** 26B-1-505(6) for committees to render advisory opinions on the series of case review questions listed there.

When the Fatality Review Committee Identified Instances of Noncompliance, DHHS Did Not Provide a Department Response as Required

If a fatality review finds that a DCFS investigation fell short of law, rule, policy, or procedure, the DHHS director is required by statute to provide a written response. This response must include an action plan to implement any recommended improvements to the department. The report and department response are then submitted to the Legislature for review to determine whether law should change.[24]

We found three fatality review reports that did not have a statutorily required department response.

There have been four reports within the past four fiscal years (2022–2025) where such a response from DHHS was required by statute. However, DHHS did not provide a response for three of those.

[24] See ***Utah Code*** 26B-1-506

OSR should ensure that these reports are being sent to the DHHS executive director as required by law and that the department is providing responses as required.

RECOMMENDATION 3.2

Administrators over the fatality review process must ensure that, when appropriate, the required response process in statute is implemented correctly.

3.2 Fatality Review Reports Have Evolved Over Time, Providing Less Useful Information for the Legislature and DHHS

As mentioned earlier in this chapter, the fatality review process was established in statute to support the goals of transparency, accountability, and process improvement. Over time, the reports issued by the fatality review committee and OSR have included less and less useful information, limiting the ability of all stakeholders involved to use the process as the oversight and improvement tool it is supposed to be. This change happened because OSR and DCFS leaders attempted to implement a new collaborative approach to process improvement. However, their efforts did not fully realize the goals of this new approach, instead pushing the fatality review process away from the transparency and oversight goals envisioned in statute.

Fatality Review Reports Are Needlessly Redacted, Making Them Hard to Read

By statute, DHHS is required to provide the Child Welfare Legislative Oversight Panel (CWLOP) and other legislative stakeholders with fatality reports that have been redacted to protect personally identifying information.[25] We believe that these redactions—along with other stylistic decisions made by OSR—make the reports difficult to understand and therefore undermine the oversight function of this process.

By redacting or obscuring details that may not need to be, OSR can make fatality review reports more difficult to understand.

OSR staff redact personally identifying information from the reports, as required by law, but also hide details that do not need to be redacted like gender and age. In one report, OSR staff used the pronoun "their" in the text to obscure the gender of a child. Another sentence in that report referred to

[25] ***Utah Code*** 26B-1-507(1)

the same child as "her" and this was not redacted, and in yet another sentence "her" was redacted.

In another report, OSR staff use the word "mother" without redaction then redacted the word "mother" twice in the following two sentences. This approach to redaction is inconsistent even within the same fiscal year. For the stakeholders in the Legislature and DHHS who read these reports, these types of needless redactions make the information difficult to understand. In fact, CWLOP members have requested changes along these very lines to make the reports easier to understand. Despite these requests from legislators in 2024, the reports remain unchanged, and legislators again raised the point in a 2025 CWLOP meeting.

OSR could improve the readability of their reports by redacting and obscuring as few details as possible.

RECOMMENDATION 3.3

The Office of Service Review should improve the readability of the fatality review reports as permitted in statute and requested by members of the Child Welfare Legislative Oversight Panel.

CWLOP Members Already Have Unrestricted Access to DCFS Case File Information

CWLOP members are granted legal authority to "access all . . . [DCFS] records, including records regarding individual child welfare cases."[26] With this in mind, we believe that the Legislature should consider whether to remove the requirement in statute that fatality review reports be redacted for CWLOP members.

Legislators serving on the CWLOP have full access to individual child welfare case records.

There are some hurdles to consider when making this change, namely that the Office of Legislative Research and General Counsel (LRGC) provides staff support for the CWLOP and are therefore also named in statute as recipients of the redacted reports. If the Legislature moves to leave the reports unredacted for the CWLOP, it may therefore want to consider whether and how LRGC should continue receiving these reports.

[26] ***Utah Code*** 36-33-103(3)(b)(i)

RECOMMENDATION 3.4

In light of the panel's existing authority to read unredacted child welfare case documents, the Legislature should consider granting unredacted access for fatality review reports to members of the Child Welfare Legislative Oversight Panel.

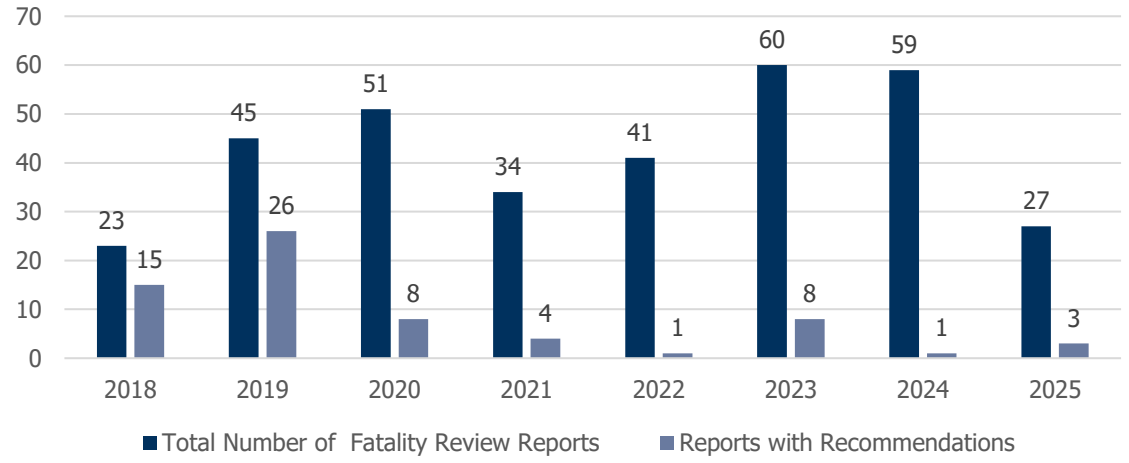
Weak Fatality Review Reports Undermine Accountability and Contribute to a Culture of Noncompliance within DCFS

Our review also found that OSR has repeatedly changed the layout and format of the fatality review reports—sometimes even during a single fiscal year. This is notable because the overall process and criteria in statute have not substantively changed since it was enacted 16 years ago. The report changes seem to have confused the focus and purpose of the documents and have negatively impacted the reports' ability to effectively communicate what statute envisions and requires.

For example, the reports have changed how they communicate the advisory opinions of the fatality committees. In older reports, there was a section of the report called "Recommendations or Concerns" that, compared to newer reports, was more candid about areas for improvement in specific cases and in DCFS at large. This section then changed to one called "Recommendations" as the reports began to report less and less information. In 2025, this section was changed to "Feedback" and, in our view, contains less information than the reports should to support meaningful oversight from Legislative and DHHS stakeholders. This idea is reflected in the number of recommendations made in fatality review reports over the last eight years.

The format of fatality review reports has changed often even though statute has remained constant.

Figure 3.2 Older Fatality Review Reports Contained More Recommendations for Improvement. Like the trend shown in Figure 3.1 earlier in this chapter, fatality committees' recommendations have decreased compared to those of past committees. To better support the statutory intent of this process, the committees and the OSR staff who support them should provide more substantive feedback in their reports.



Source: Auditor analysis of OSR fatality review reports from 2018 to 2025.

Leadership at OSR and DCFS explained that the shift in reporting habits happened in response to recommendations from consultants about how to soften feedback to improve agency culture. While we agree that unfairly scapegoating staff is not an effective way to manage an organization and improve operations, clearly identifying problems and potential solutions is a sound management principle. The fatality review process must regain its former power to better respond to the statutory purposes of the program. This will also reestablish the process as an independent oversight function over the work done in DCFS. As shown in the prior chapters of this report, this type of independent oversight is sorely needed.

Complete List of Audit Recommendations

Complete List of Audit Recommendations

This report made the following eight recommendations. The numbering convention assigned to each recommendation consists of its chapter followed by a period and recommendation number within that chapter.

Recommendation 1.1

Senior leadership at the Division of Child and Family Services should define objectives and performance targets for Child Protective Services investigation caseworkers and supervisors, along with clear procedures for what must happen when staff fall below those targets. The success of the performance targets will be measured through improved outcomes for children and families.

Recommendation 1.2

Once the Division of Child and Family Services has established its key objectives, activities, and performance targets, senior leadership should create data tools that must be used throughout the organization to help ensure that staff are performing as expected.

Recommendation 2.1

Supervisors over Child Protective Services teams, including child welfare administrators, should hold their caseworkers accountable to requirements in the DCFS practice guidelines to improve child safety.

Recommendation 2.2

Higher levels of management within the Division of Child and Family Services should set a stronger tone at the top, embracing and modeling a culture of control in which high-quality work is expected and low-quality work is routinely identified and corrected.

Recommendation 3.1

Fatality committees and the Office of Service Review should provide clear and direct feedback in response to the mandate in ***Utah Code*** 26B-1-505(6) for committees to render advisory opinions on the series of case review questions listed there.

Recommendation 3.2

Administrators over the fatality review process must ensure that, when appropriate, the required response process in statute is executed correctly.

Recommendation 3.3

The Office of Service Review should improve the readability of the fatality review reports as permitted in statute and requested by members of the Child Welfare Legislative Oversight Panel.

Recommendation 3.4

In light of the panel's existing authority to read unredacted child welfare case documents, the Legislature should consider granting unredacted access for fatality review reports to members of the Child Welfare Legislative Oversight Panel.

Appendix

A. Additional Detail for Chapter 1 Data Analyses

This appendix shows additional detail for the analyses shown in figures 1.1, 1.2, and 1.3 of Chapter 1. In addition to the percentage of noncompliance shown there, these figures show the total cases affected for each office for each analysis.

Figure A.1 In Fiscal Year 2025, CPS Caseworkers Missed the Priority Deadline for Face-to-Face Child Contact on Just Over 3,200 Cases. The wide variation in how well each office did shows obvious opportunities for improvement.

CPS Office	Percent of Cases with Missed Deadlines	Total Cases Affected
Orem	27%	149
Brigham City	26%	166
Logan	26%	235
Cedar City	18%	106
Mid Towne	17%	541
Oquirrh	16%	266
Ogden	16%	376
Moab	15%	13
Roosevelt	15%	36
Heber	14%	64
South Towne	14%	253
Metro	13%	215
Vernal	13%	49
St. George	11%	129
Richfield	11%	31
Tooele	10%	75
Manti	10%	17
Clearfield	9%	150
Nephi	9%	14
American Fork	9%	61
Provo	8%	135
Bountiful	6%	63
Castle Dale	6%	5
Price	5%	13
Salem	5%	38
Blanding	3%	2

Source: Auditor analysis of DCFS case data.

Figure A.2 In Fiscal Year 2025, Caseworkers Either Did Not Complete or Properly Document Statutorily a Required Safety Assessment for More than 7,800 Cases. This is the primary method CPS has to make evidence-based decisions about child safety. This must improve.

CPS Office	Percent of Safety Assessments That Were Not Timely	Total Cases Affected
Richfield	76%	220
Nephi	73%	113
Orem	68%	374
Blanding	68%	47
St. George	63%	744
Cedar City	61%	366
American Fork	58%	402
Manti	52%	92
Moab	43%	36
Provo	43%	725
Heber	41%	193
Roosevelt	35%	85
Oquirrh	35%	589
Metro	32%	511
South Towne	30%	557
Clearfield	30%	490
Brigham City	29%	181
Logan	25%	225
Ogden	24%	588
Tooele	23%	175
Castle Dale	23%	18
Mid Towne	22%	693
Salem	21%	160
Vernal	17%	63
Price	13%	32
Bountiful	13%	132

Source: Auditor analysis of DCFS case data.

Figure A.3 Among Cases that Closed in 2025, CPS Supervisors Failed to Approve Extensions for More Than 4,600 Cases. A failure to issue case extensions is a strong indicator that supervisors are not actually paying attention to their teams' cases. This can increase the risk of harm to children who rely on the division for ongoing protection during investigations.

CPS Office	Percentage of Cases That Did Not Receive an Extension When Needed	Total Cases Affected
Heber	90%	159
South Towne	68%	728
Nephi	65%	66
Logan	65%	233
Metro	62%	412
Brigham City	62%	224
Blanding	61%	19
Tooele	61%	191
Ogden	60%	579
Manti	55%	67
Vernal	52%	103
Cedar City	51%	95
Roosevelt	51%	67
American Fork	51%	193
Richfield	51%	98
Castle Dale	43%	17
Clearfield	41%	161
St. George	38%	259
Provo	37%	245
Oquirrh	35%	235
Moab	30%	9
Bountiful	29%	29
Price	27%	23
Mid Towne	25%	312
Orem	18%	61
Salem	17%	30

Source: Auditor analysis of DCFS case data.

Agency Response Plan

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

STACEY BANK, MD
Executive Medical Director

TONYA HALES
Deputy Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

January 20, 2026

Mr. Kade Minchey
Utah Legislative Auditor General
Utah Capitol Complex
P.O. Box 145315
Salt Lake City, UT 84114-5315

Dear Mr. Minchey,

Thank you for the opportunity to respond to the recommendations in *A Performance Audit of the Division of Children and Family Services* (Report No. 2026-03). This letter includes the response from the Utah Department of Health and Human Services (department), the Division of Children and Family Services (DCFS), and the Office of Service Review (OSR). The public entrusts in us the responsibility of ensuring the health and safety of Utah's children, among the most serious functions of our department. The recommendations included in this audit will help ensure that the operations of our department meet these responsibilities.

We extend our sincere appreciation to the Office of the Legislative Auditor General for their comprehensive review and agree that maintaining the highest standard of child safety is a solemn obligation. While we are gratified that the audit recognized the profound dedication and professional integrity of our frontline staff, we remain deeply mindful of our duty to address the concerns raised.

On behalf of the department, we formally concur with the recommendations set forth in this report. We are prepared to implement them as we work collectively to improve protection for every child within our oversight.

Sincerely,

Tracy S. Gruber
Executive Director

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Recommendation 1.1. Senior leadership at the Division of Child and Family Services should define objectives and performance targets for Child Protective Services investigation caseworkers and supervisors, along with clear procedures for what must happen when staff fall below these targets. The success of the performance targets will be measured through improved outcomes for children and families.

Department Response: The Department of Health and Human Services (department or DHHS) concurs with this recommendation. Senior Leadership at the Division of Child and Family Services affirms our deep commitment to child safety and ensuring the system supports high quality outcomes for the children and families of Utah. Leadership recognizes the vital importance of ensuring that Child Protective Services (CPS) workers, supervisors, and administrators have clear job expectations with defined performance standards along with strong mechanisms to support that critical policies and procedures are followed. Rigorous adherence to these key policies is essential to preventing systemic failures and to secure optimal outcomes for children and families.

What: CPS investigations operate under a variety of established policies and procedures designed to ensure timely and effective assessment of safety and risk for children and there are additional policies and metrics at the state and federal level in addition to those highlighted in the report. While the application of key policies is successful in most cases, DCFS recognizes the need to strengthen internal control and oversight to ensure consistent adherence to these critical requirements across the organization.

All CPS supervisors and administrators have performance plans specific to their program area and are expected to regularly assess and monitor performance levels, taking action through performance improvement plans or disciplinary measures, as warranted and ensure sustained high-quality performance. They are also expected to have monthly one-on-one meetings with employees as well as conduct formal quarterly evaluations. Although current performance plans for CPS personnel have clear objectives and measurements, DCFS agrees these can be bolstered through the addition of performance targets for key critical policies and guidance on what actions to take when performance falls below these standards.

How: DCFS has initiated a comprehensive effort to identify critical CPS performance objectives and targets. This undertaking is centered on the timely and effective assessment of child safety and risk, outlining acceptable timeframes for key investigative activities, and the assurance of consistent policy adherence across the organization. This initiative includes setting clear,

quantifiable performance targets and measurable indicators for evaluating caseworker and supervisor effectiveness that will be included in employee performance plans.

With clear objectives, performance targets, and adherence monitoring procedures in place, senior leadership will provide comprehensive initial and ongoing training and guidance across all organizational levels.

To strengthen accountability beyond the currently required monthly and quarterly evaluations, new data tools and reporting mechanisms will be implemented. Additionally, a new Quality Assurance tool has been developed for use by supervisors and administrators on individual cases to evaluate whether completed actions on a case are completed as intended. Supervisors will be provided with clear expectations for leveraging data reports to both assess overall employee performance and immediately identify cases which may need immediate attention. Additionally, a system of automated notifications will alert administrators and senior management when key policies are not met in individual cases, enabling immediate intervention and support.

Comprehensive data reports will be provided across all levels (caseworker, supervisor, office, and region) to facilitate the early identification of systemic concerns and assess. The consistent, effective use of these data reports will be formally integrated into the performance plans for all CPS personnel. The specifics regarding the development and deployment of these data tools are detailed further in the response to Recommendation 1.2. DCFS will coordinate with DHRM for guidance on establishing standards for prompt, effective, and appropriate action when expected performance levels are not consistently achieved.

When: Ongoing, and fully implemented by July 2026

Responsible Staff: Tonya Myrup, Director, Division of Child and Family Services; Monica Jimenez, Human Resource Field Director, Division of Human Resource Management

Recommendation 1.2. Once the Division of Child and Family Services has established its key objectives, activities, and performance targets, senior leadership should create data tools that must be used throughout the organization to help ensure that staff are performing as expected.

Department Response: DHHS concurs with this recommendation.

What: Data is essential to DCFS' success, serving as a critical metric for tracking the effective implementation of policies and supporting the evaluation of child safety and risk. Performance measures, such as meeting priority and assessment timeframes and completing investigations in a timely manner, are vital in child welfare as they help monitor the implementation of safeguarding

activities. Monitoring caseworkers' adherence to these performance measures is an important way to verify that protective measures are being followed according to policy and practice standards. While these protective measures on their own do not guarantee the child's safety, meeting priority and assessment timeframes and the timely completion of investigations provides caseworkers the best opportunity to protect children and to keep families together whenever possible.

Additionally, it is essential that there is an accurate and complete record in the case file that documents the completion of the key policy and supports the action and decisions made by DCFS.

How: DCFS has developed and continues to refine data tools to strengthen management oversight and empower leadership across all levels (regional and state) by providing greater access to data, including at the individual caseworker level. DCFS will provide improved guidance and expectations in its use. This strategy is designed to ensure frontline teams receive the necessary support and direction to drive improved outcomes of child safety. Clear expectations will be set for routine utilization of the data reports by managers, administrators, and senior leadership, directly supporting improved timeliness and adherence to these critical policies and practices. Furthermore, a progressive notification system will be implemented, automatically escalating alerts for non-adherence, ensuring prompt intervention and targeted support where needed. These dashboards and notifications will be instrumental in the immediate identification of caseworkers or supervisors requiring additional assistance.

As part of the effort to implement a balanced monitoring framework that includes both process and outcome measures, DCFS has also implemented a quality assessment (QA) tool as referenced in the response to Recommendation 1.1. This will help balance the emphasis on compliance with policy along with an evaluation whether the documentation is of sufficient quality to justify and support actions and decisions made in the case. The QA tool will ensure DCFS continues to make the connection between completion and the effective implementation of the policy, forming a more complete picture as to whether there are improved outcomes for children.

When: Ongoing, and fully implemented by July 2026

Responsible Staff: Tonya Myrup, Director, Division of Child and Family Services

Recommendation 2.1. Supervisors over Child Protective Services teams, including child welfare administrators, should hold their caseworkers accountable to requirements in the DCFS practice guidelines to improve child safety.

Department Response: DHHS concurs with this recommendation. DCFS leadership is committed to ensuring that all teams, including supervisors and child welfare administrators, hold ourselves and our teams to the highest standards of practice as defined in DCFS guidelines.

What: As noted in response to Recommendation 1.1, all CPS supervisors and administrators have performance plans specific to their program area and are expected to regularly assess and monitor performance levels, taking action through performance improvement plans or disciplinary measures, as warranted and ensure sustained high-quality performance. They are also expected to have monthly one-on-one meetings with employees, as well as conduct formal quarterly evaluations. Although current performance plans for CPS personnel (supervisors and administrators) have clear objectives and measurements, DCFS agrees these can be bolstered through the addition of clear expectations and guidance on actions to be taken when performance falls below these standards.

How: As noted in response to Recommendation 1.1, clear, measurable performance targets will be formally integrated into CPS supervisor and administrator performance plans to actively support staff success, drive improved outcomes, and ensure better results for children and families. The development of enhanced data dashboards and the effective use of databoards referred to in response to Recommendation 1.2 will provide essential support to supervisors in and administrators in readily identifying workers missing key policies in individual cases or individuals or supervisors falling below performance standards.

Supervisors and administrators are expected to model accountability, transparency, and ownership. Using skills learned through DCFS' Leadership Empowerment and Development training and DHHS' Leadership Competency Series, supervisors and administrators will coach and address shortcomings with clear steps for improvement, provide a supportive environment, while documenting and monitoring progress with a clear expectation that subpar performance will not be tolerated. DCFS will consult with DHRM on establishing standards for prompt, effective performance improvement plans when expected performance levels are not met or if disciplinary action is warranted.

When: Ongoing, and fully implemented by July 2026

Responsible Staff: Tonya Myrup, Director, Division of Child and Family Services; Monica Jimenez, Human Resource Field Director, Division of Human Resource Management

Recommendation 2.2. Higher levels of management within the Division of Child and Family Services should set a stronger tone at the top, embracing and modeling a culture of control in which high quality work is expected and low quality work is routinely identified and corrected.

Department Response: DHHS concurs with this recommendation.

What: DCFS regional and state leadership are fully committed to organizational excellence, prioritizing the achievement of high-quality work. Leadership is dedicated to leading by example, investing in robust leadership development, and establishing transparent and effective standards for exceptional performance. DCFS leadership is fully committed to fostering a culture of quality and high performance that starts at the top and is infused throughout the division. Leadership recognizes this is not a one-time fix, but a sustained, ongoing effort and that every position within DCFS is responsible for positive outcomes.

How: DCFS senior leadership will create a strategic plan to support the implementation and sustainability of recommendations made in this report. The plan will include the creation of performance targets, clear performance monitoring, accountability when performance falls below standards, and setting expectations for excellence, supporting the achievement of DCFS's primary objective, safe children. The plan will include specific training and messaging to support the development of a culture where the highest quality work is expected.

When: Ongoing, and fully implemented by July 2026

Responsible Staff: Tonya Myrup, Director, Division of Child and Family Services

Recommendation 3.1. Fatality committees and the Office of Service Review should provide clear and direct feedback in response to the mandate in Utah Code 26B-1-505(6) for committees to render advisory opinions on the series of case review questions listed there.

Department Response: DHHS concurs with this recommendation. The Office of Services Review (OSR) is committed to a thorough and comprehensive fatality review process and that the fatality reports have accurate and complete information.

What: OSR recognizes that the fatality review process is vital for identifying systemic issues and is critical in ensuring accountability and oversight for our most vulnerable population. OSR commits to evaluating the current fatality review process to strengthen practices that identify both systemic concerns and case-specific quality and compliance. The fatality review process will be designed to ensure accountability, identify and resolve systemic issues, and propose effective recommendations for strengthening DHHS systems.

How:. OSR will review the current fatality review process to ensure a comprehensive case review is completed that will verify compliance with standards and policies, as well as including a process to identify systemic concerns or policy change recommendations. OSR will also

evaluate the fatality committee and clarify their their role in their review process in conducting a thorough review of the case and to render an advisory opinion as dictated in statute, specifically;

- If relevant laws, rules, policies, and procedures for the qualified individual and their family were followed.
- If the response to the near fatality or death was appropriate.
- Whether changes to existing laws, rules, policies, or procedures should be recommended.
- If additional training is necessary.

OSR is dedicated to making this process a part of continuous quality improvement and accountability. This ensures that both DHHS and our legislative partners have the essential information needed to make informed decisions about system changes, improvements, and policy.

When: June 30, 2026

Responsible Staff: Carrie Bambrough, Director, Division of Continuous Quality and Improvement; Jessica Hooper, Director, Office of Service Review

Recommendation 3.2. Administrators over the fatality review process must ensure that, when appropriate, the required response process in statute is implemented correctly.

Department Response: The department concurs with this recommendation. OSR is fully committed to transparency and accountability concerning fatality reports. We understand the necessity of meeting statutory requirements to ensure the necessary response, enabling the implementation of changes, and informing lawmakers so that relevant legislation can be reviewed and amended as needed.

What: OSR recognizes the importance of having a defined process for responding to and implementing recommendations stemming from fatality reviews. We are committed to ensuring our procedures adhere to all statutory requirements and that there is clear communication on recommendations so appropriate responses and actions can be taken by DHHS leadership and lawmakers.

How: OSR recognizes the importance of a clear process for responding to and implementing recommendations from fatality reviews. To address this, OSR revised this procedure in July 2024 to clarify the process and requirements for responding to fatality reports. To ensure ongoing compliance, OSR will review the updated procedure and make any necessary revisions. OSR will retrain all the fatality review staff on the revised policy and procedure. Additionally, OSR will establish a secondary review process, including a regular review of fatality review reports, so that recommendations are appropriately addressed and the process meets all statutory criteria.

We are committed to the regular review and revision of our policy and process to maintain continuous compliance with statute.

When: April 1, 2026

Responsible Staff: Tracy S. Gruber, Executive Director, Department of Health and Human Services; Carrie Bambrough, Director, Division of Continuous Quality and Improvement; Jessica Hooper, Director, Office of Service Review

Recommendation 3.3. The Office of Service Review should improve the readability of the fatality review reports as permitted in statute and requested by members of the Child Welfare Legislative Oversight Panel.

Department Response: DHHS concurs with this recommendation. The fatality review team is committed to providing accurate and detailed information related to fatalities or near fatalities while also protecting sensitive and protected information by adhering to DHHS privacy and security standards for identifiable information.

What: OSR understands the importance of readability of the fatality reports and is committed to ensure that information provided in the fatality reports is clear, accurate, and comprehensive so that division and department leadership, as well as law makers, have the information they need to identify system or policy level changes. We are committed to presenting the details of these often lengthy cases in the most concrete and understandable manner possible, ensuring accuracy and clarity.

How: OSR will review the format of the reports to improve readability with input from our partner agencies. OSR will also work in conjunction with the DHHS Office of Information, Privacy and Security to ensure that all redactions are done in alignment with DHHS policy and will implement training on redaction for all team members to improve accuracy and appropriateness of what should be redacted. We commit to reviewing the fatality review report form each year and incorporating any feedback as needed while still adhering to the statute.

When: April 30, 2026

Responsible Staff: Carrie Bambrough, Director, Division of Continuous Quality and Improvement; Jessica Hooper, Director, Office of Service Review; Patrick Thomas, Director, Office of Information, Privacy, and Security

Recommendation 3.4. In light of the panel's existing authority to read unredacted child welfare case documents, the Legislature should consider granting unredacted access for fatality review reports to members of the Child Welfare Legislative Oversight Panel.

Department Response: The department concurs with this recommendation. We look forward to working with the Utah Legislature to understand and work through the logistics of granting unredacted access for those reports that are sent to the Child Welfare Legislative Oversight Panel. The Division of Continuous Quality Improvement is available to discuss legislation that would grant unredacted access to members of that panel that balances the privacy interest of individuals while providing needed information to lawmakers.

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