CALIFORNIA STATE AUDITOR

# Child Welfare Services

California Can and Must Provide Better Protection and Support for Abused and Neglected Children

October 2011 Report 2011-101.1

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# CALIFORNIA STATE AUDITOR
## Bureau of State Audits

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October 27, 2011 2011-101.1

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the provision of child welfare services (CWS) to abused and neglected children. This report concludes that California can and must provide these children better protection and support. Specifically, the Department of Social Services (Social Services), which oversees the CWS system, needs to use the Department of Justice's Sex and Arson Registry to better ensure that children—when removed from their homes—are provided safe out-of-home placements. Our comparison of addresses for registered sex offenders to Social Services' addresses for licensed facilities and out-of-home child placements found more than 1,000 matches. In July 2011 our office referred these address matches to Social Services for investigation. Social Services reported in October 2011 that it and county CWS agencies had investigated nearly all of these matches and found several registered sex offenders living or present in licensed facilities. Specifically, Social Services indicates it has begun legal actions against eight licensees (four temporary suspension orders and four license revocations) and issued 36 immediate exclusion orders (orders barring individuals from licensed facilities).

This report also concludes that county CWS agencies' increased reliance on foster family agencies has led to unjustified increases in out-of-home placement costs. The increased reliance on foster family agencies, which were originally meant as substitutes for expensive group homes for children with elevated treatment needs, has instead been accompanied by a matching drop in the use of less expensive licensed foster homes. One potential explanation for this trend is that Social Services does not require county CWS agencies to document the treatment needs of children who are placed with foster family agencies. Additionally, Social Services could not provide us with support for the monthly rate it pays foster family agencies—a rate that includes a 40 percent administrative fee.

Our review of county CWS agencies' investigatory and ongoing case management practices found that they generally comply with state regulations and county policies. Nonetheless, the agencies still need to improve the timeliness of investigations and the consistency of ongoing case visits. Our review also found that county CWS agencies generally performed required background checks before placing children in out-of-home placements, although they did not always forward information regarding instances of abuse or neglect to the Department of Justice, as required by state law at the time of our audit. Finally, we determined that county CWS agencies that do not formally conduct internal evaluations of the services they delivered to a family prior to a child's death from abuse or neglect are missing opportunities to identify needed changes that may prevent similar future tragedies.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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# Summary

## Results in Brief

The Department of Social Services (Social Services) oversees the efforts of county child welfare services (CWS) agencies to protect California children from abuse and neglect. When these agencies determine that children's safety is at risk, they have the authority to remove them from their homes and place them with relatives, foster parents, or group homes (placements). Both Social Services and county CWS agencies need to better ensure that these placements are safe. Specifically, Social Services could make better use of the Department of Justice's (Justice) Sex and Arson Registry (sex offender registry) to ensure that sex offenders are not living or working among children in the CWS system. We compared the addresses of sex offenders in this registry with the addresses of Social Services' and county's licensed facilities, as well as the addresses of CWS placements, and found over 1,000 address matches, nearly 600 of which are high risk and in need of immediate investigation.

We provided these address matches to Social Services in July 2011. In October 2011 Social Services stated that it and county CWS agencies had investigated 99 percent of the address matches. Social Services indicates it has begun legal actions against eight licensees (four temporary suspension orders and four license revocations) and issued 36 immediate exclusion orders (orders barring individuals from licensed facilities). In six of the eight legal actions, Social Services found registered sex offenders living or present in licensed facilities. The department added that counties found 36 registered sex offenders having "some association" with county foster homes and took actions, including removing foster children from homes and ordering registered sex offenders out of homes.

We also found that Social Services' established oversight mechanisms—on-site reviews of its licensed facilities every five years and licensing reviews of county CWS agencies to which it has delegated licensing authority every three years—are lagging behind statutory requirements and department-set goals. Social Services cites the lack of resources as the primary reason why it has not implemented an automated sex offender address match and why its oversight mechanisms are falling short of requirements.

For their part, the county CWS agencies appear to be performing required background checks of applicable individuals before placing children in foster homes and generally appear to remove children quickly if the home is found to be inappropriate. However, they could improve their follow-up and communication related to allegations against a foster home or parent. Specifically, these

***Audit Highlights . . .***

*Our review of the child welfare services (CWS) system, which the Department of Social Services (Social Services) oversees, revealed the following:*

- *We found over 1,000 addresses in the Department of Justice's (Justice) Sex and Arson Registry that matched the addresses of Social Services' or county's licensed facilities or homes of children in the CWS system.*
- *After investigating the address matches we provided, Social Services indicates it has begun legal action against eight licensees and issued 36 immediate exclusion orders (orders barring individuals from licensed facilities), and counties removed children and ordered sex offenders out of homes.*
- *Social Services' mechanisms for overseeing its licensees are lagging behind statutory requirements and department-set goals.*
- *Although county CWS agencies generally performed required background checks of applicable individuals and quickly removed children if a home is found to be inappropriate, they did not consistently notify Social Services of deficiencies or forward required information to Justice.*
- *The number of children in the CWS system has dramatically decreased in the last 10 years.*
- *The percentage of children placed with foster family agencies has continued to increase over the last decade, which we estimate has resulted in spending an additional $327 million in foster care payments between 2001 and 2010.*

*continued on next page . . .*

» *County CWS agencies generally comply with state regulations and county policies but need to improve the timeliness of investigations and the consistency of ongoing case management visits.*

» *While not required by law, some agencies have instituted formal death reviews that examine what the agencies could have done differently or better to prevent the death of the child.*

agencies do not consistently notify Social Services' Community Care Licensing Division of allegations involving its licensees, and they do not always forward required information regarding instances of abuse or neglect to Justice.

While the number of children in placement has dramatically decreased in the last 10 years, the percentage of children placed with foster family agencies, which recruit and certify foster homes and whose monthly compensation is significantly higher than state- or county-licensed foster homes, has continued to increase. The dramatic growth in the use of foster family agencies, which originally were meant to be a substitute for group homes for children with elevated treatment needs, has been accompanied by a matching drop in the percentage of children placed in state- and county-licensed foster homes and a fairly steady percentage of children in group home placements. These data indicate that, rather than significantly reducing expensive group home placements, growth in foster family agencies has reduced relatively inexpensive licensed foster home placements.

A potential explanation for this trend is that, in contrast to requirements related to group home placements, Social Services does not require county CWS agencies to document the treatment needs of children placed with foster family agencies. The counties we visited admitted that some placements with foster family agencies are a function of convenience and necessity—for example, the unavailability of state- or county-licensed foster homes—and not the elevated treatment needs of children. Additionally, until a recent lawsuit, foster homes certified under foster family agencies received significantly higher monthly payments than foster homes licensed by the State or a county. County officials indicated that this pay differential contributed to their difficulty in recruiting licensed foster homes. We estimate that the growth in the percentage of placements with foster family agencies has resulted in spending an additional $327 million in foster care payments between 2001 and 2010—costing an additional $61 million in 2010 alone.

Our examination of the investigatory and ongoing case management practices of county CWS agencies found that they are generally complying with state regulations and county policies. However, improvements in the timeliness of investigations and in the consistency of ongoing case management visits are still needed. In recent years Social Services, which provides leadership and oversight to county CWS agencies, has shifted from a monitoring system focused solely on regulatory compliance to an accountability system that measures outcomes for children who have experienced, or are at risk of experiencing, abuse or neglect (outcome review). This outcome review appears to have resulted in some improved compliance with investigatory and case

management requirements. Even so, Social Services could improve some of its measures of system performance and could use its Child Welfare Services/Case Management System (CWS/CMS) to determine if efforts to reduce the number of cases or referrals per worker (caseloads) have been effective.

Although the State has various means of analyzing child deaths and identifying improvements that can be made, one of the more effective locations for this type of review resides at the local level, within the county CWS agencies that are often most familiar with local and family-specific histories. While not required by law to do so, some agencies have instituted formal death reviews that examine what the agencies could have done differently or better to prevent the death of the child. However, other counties are missing opportunities to identify potential improvements because they do not conduct such reviews. Social Services could encourage this practice by including information on whether these death reviews took place in its annual report to the Legislature on child deaths.

### Recommendations

To ensure that vulnerable individuals, including foster children, are safe from sex offenders, Social Services should complete a follow-up on any remaining address matches our office provided in July 2011 and take appropriate actions, as well as relay information to Justice or local law enforcement for any sex offenders not in compliance with registration laws.

Social Services should conduct regular address comparisons using Justice's sex offender registry and its Licensing Information System and CWS/CMS. If Social Services believes it needs additional resources to do so, it should justify and seek the appropriate level of funding.

To provide sufficient oversight of county CWS agencies with delegated authority to license foster homes, Social Services should complete comprehensive reviews of these agencies' licensing activities at least once every three years.

To ensure that its licensees (state-licensed foster homes, foster family agencies, and group homes) are in compliance with applicable requirements and that children are protected, Social Services should complete on-site reviews at least once every five years as required by state law.

To ensure that county CWS agencies send required reports of abuse and neglect to Justice, Social Services should remind the agencies of applicable requirements and examine the feasibility of using CWS/CMS to track compliance with these statutory provisions.

To ensure that payments to foster family agencies are appropriate, Social Services needs to create and monitor compliance with clear requirements specifying that children placed with these agencies must have elevated treatment needs that would require a group home placement if not for the existence of these agencies' programs.

To achieve greater cooperation from county CWS agencies and to make it possible for some of these agencies to improve their placement practices, Social Services should develop a funding alternative that allows the agencies to retain a portion of state funds they save as a result of reducing their reliance on foster family agencies and only making placements with those agencies when justified by the elevated treatment needs of a child.

Social Services should refine and use CWS/CMS to calculate and report county CWS caseloads.

To improve agency practices and increase the safety of children within the CWS system, all agencies should formally review the services that they delivered to each child before he or she died of abuse or neglect.

To encourage counties to perform internal child death reviews for children with CWS histories, Social Services should provide in its annual report information on whether county CWS agencies conducted formal reviews of child deaths with prior CWS history.

### Agency Comments

Social Services generally agreed with our findings and recommendations and outlined actions it plans to take in response to the recommendations. In some instances, Social Services stated that it would examine our recommendations in the context of ongoing CWS reform efforts and in other instances, it disagreed with our specific recommendations but proposed alternative actions.

# Introduction

## Background

California has a system of laws and agencies designed to prevent and respond to child abuse and neglect. This system—often called child protective services—is part of a larger set of programs commonly referred to as child welfare services (CWS). Generally, the CWS system provides family preservation services, removes children from unsafe homes, provides for the temporary placement of these children with relatives or into foster and group homes, and facilitates legal guardianship or the adoption of these children into permanent families when appropriate. While state law requires the Department of Social Services (Social Services) to provide system oversight, county CWS agencies carry out required activities.

California CWS agencies received 480,000 allegations of maltreatment of children in 2010 and substantiated 87,000 of these allegations through their investigatory efforts. In addition, 57,000 children were in out-of-home placements in California as of January 2011; this was down from over 97,000 10 years earlier.[1] According to Social Services' estimates, California's systemwide child welfare budget from federal, state, and county funding sources was approximately $5.5 billion in fiscal year 2010–11.

## Roles of Entities Involved in Child Welfare Services

California's Welfare and Institutions Code requires the State, through Social Services and county welfare departments, to establish and support a CWS system. California uses a state-supervised, county-administered model of CWS governance. Under this model, each of California's 58 counties establishes and maintains its own program, and Social Services monitors and provides support to counties through oversight, administrative services, and development of program policies and regulations. State law requires both county CWS agencies and local law enforcement (which may share information) to receive and investigate allegations of child abuse or neglect and make immediate decisions about whether to temporarily remove a child from his or her home. Juvenile courts hear the facts surrounding any recent removal and then decide on the best course of action for the child. If the child becomes a dependent of the court, the county CWS agency provides ongoing case management and regular reports to the court. Reunification of the child with his or her original family is a priority

[1] Source: Unaudited data from CWS reports for California, retrieved from the University of California at Berkeley Center for Social Services Research Web site.

until the court decides this is not in the best interest of the child, which then allows the child to be adopted by parents recruited by Social Services or the county CWS agency.

### *Social Services' Role*

Two of Social Services' divisions have lead roles in California's CWS system—the Children and Family Services Division (family services division) and the Community Care Licensing Division (licensing division). The family services division is responsible for providing oversight of the State's CWS system from early intervention activities to permanent placement services. As shown in Figure 1, this division consists of five branches and the Office of the Foster Care Ombudsman. The licensing division provides oversight and regulatory enforcement for more than 85,000 licensed community care facilities statewide, including licensing foster and group homes that house children removed from unsafe homes. It screens and inspects facilities, ensures licensed facilities are in compliance with applicable laws and regulations, and takes corrective action when a facility violates or cannot meet such laws and regulations.

**Figure 1**
**Divisions of the Department of Social Services**


Source: Department of Social Services.

Social Services receives and distributes federal and state funding that provides support for CWS agencies and ensures that counties provide matching funds at specified levels. Social Services also provides social worker training and oversees operation of the statewide automated Child Welfare Services/Case Management System (CWS/CMS), which is used by counties to manage and document their case management activities. Finally, Social Services monitors county child welfare systems through an outcome-based, quality assurance system called the California Child and Family Services Review. This review uses a continuous, three-year cycle of peer reviews, self-assessments, and improvement plans to assess, monitor, and track county CWS performance.

### *The Role of County CWS Agencies*

Under Social Services' oversight and their respective board of supervisors' governance, each of California's 58 counties administers its own CWS program. Because the counties differ widely in population, economic base, and demographics, each has some flexibility in determining how to best meet the needs of its children and families. Although they have flexibility, under state law each county must provide four key services:

- Emergency response—Provides in-person, 24-hour response to reports of child abuse, neglect, and exploitation with the purpose of maintaining the child safely in his or her home or protecting the child's safety through emergency removal and foster care placement.

- Family maintenance—Time-limited services designed to prevent or remedy neglect, abuse, and exploitation in an attempt to avoid separating children from their families.

- Family reunification—Time-limited services designed to reunite children with their families subsequent to their removal for safety reasons.

- Permanent placement—Services designed to ensure that children who have been removed from families find new safe, stable, and permanent homes in which to grow up.

In the short term, county CWS agencies have the ability to make decisions regarding the type and duration of services provided to an individual child or family, but ultimately juvenile dependency courts make decisions regarding the long-term needs of dependent children in the CWS system.

### *The Role of the Court*

The juvenile court is a division of the superior court that handles child abuse and neglect cases. When a child has suffered, or is at risk of suffering, abuse or neglect from the child's parent or guardian, the juvenile court may place him or her under a program of supervision and order that services be provided or may declare the child a dependent of the court (dependent child) as discussed in more detail in the next section. The county CWS agencies act as the administrative arm of the court, providing regular updates and carrying out the court's decisions regarding the child.

**Mandated Reporters**

California law requires various individuals to report known or suspected abuse. Mandated reporters include the following:

- County welfare workers
- Police and probation officers
- Clinical social workers
- Clergy, except in certain instances
- School teachers and counselors
- Employees of day care facilities
- Nurses and physicians
- Commercial film and photographic print processors

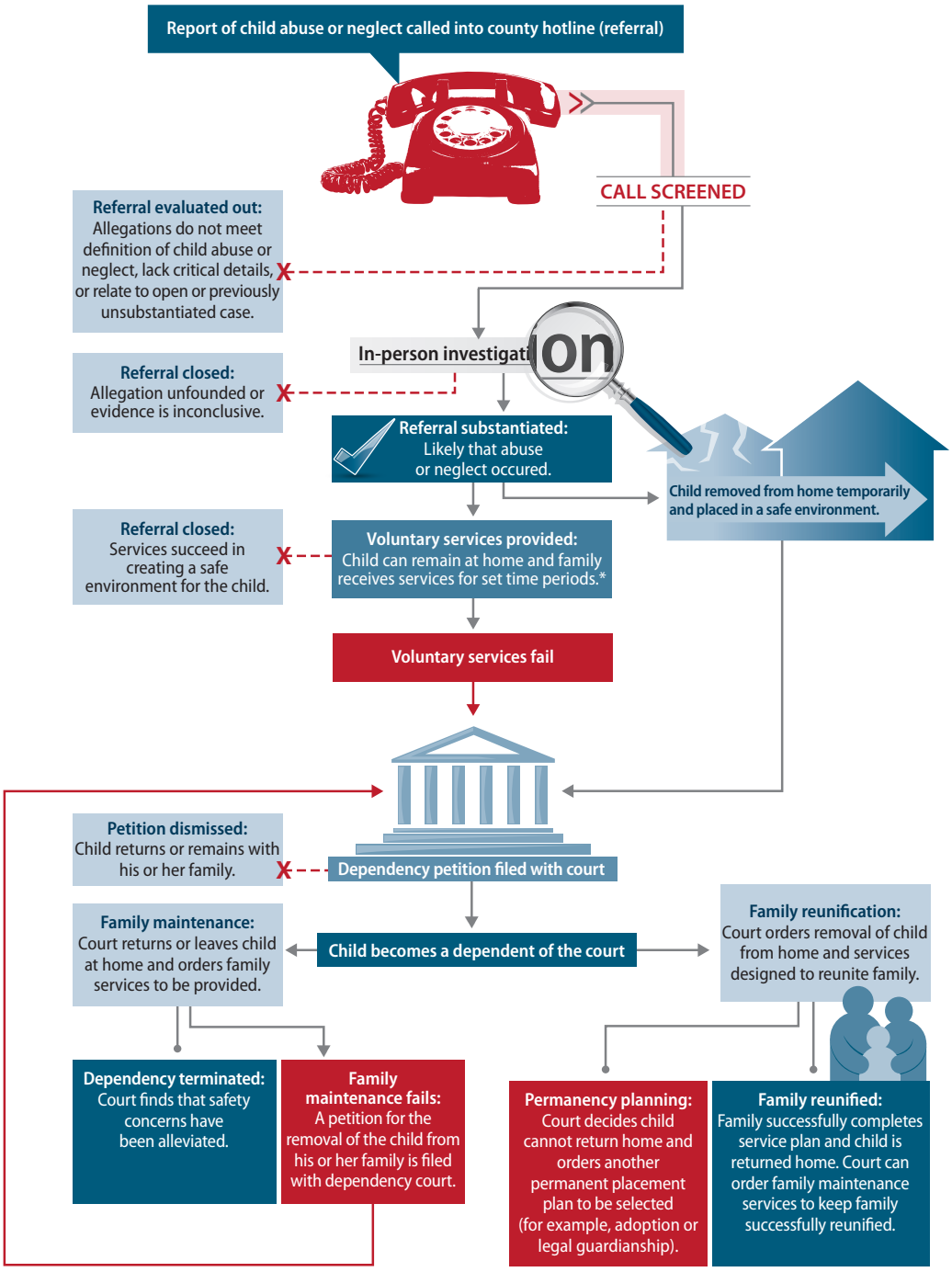
Source: California Penal Code, sections 11165.7 and 11166.

## The Child Welfare Services Process

Although variations exist, the typical CWS process begins when a report of suspected child abuse or neglect (referral) is called into a county child abuse hotline by a mandated reporter (see text box) or a concerned individual. The call is screened by a social worker who assesses the risk to the child and decides whether the referral should be evaluated out (no further action is taken) or whether an in-person investigation must be conducted immediately or within a 10-day period. Referrals from law enforcement must be investigated in person and cannot be evaluated out unless law enforcement has already investigated and determined that there is no indication of abuse or neglect. Although county policies for response times vary, an immediate in-person investigation is typically required within two to 24 hours. State law requires an immediate investigation in all situations where a child is in imminent danger of physical pain, injury, disability, severe emotional harm, or death. State law requires an in-person investigation within 10 days when a child is not in imminent danger (for example, when the child is in a safe place, such as a hospital or a relative's home where the perpetrator no longer has access to him or her).

If a county determines through its investigation that the allegation of abuse or neglect is unfounded, or if evidence is inconclusive, the referral is closed. As indicated in Figure 2, once a referral is substantiated, the child may either remain at home while voluntary services are provided or be removed temporarily from the home by the social worker or law enforcement and placed in a safe environment. All referrals must either be closed or substantiated within 30 calendar days of the initial removal of the child or the in-person investigation, or by the date of a juvenile court hearing, whichever comes first.

**Figure 2**
Major Components and Processes of the Child Welfare System




Sources: California Welfare and Institutions Code; Department of Social Services' *Child Welfare Services Manual*; Administrative Office of the Courts' Web site; and dependency flow charts.

* If a voluntary placement agreement occurs, state law allows a county welfare department to place the child outside the home within a specified time frame while the family receives voluntary services.

When a social worker or law enforcement officer removes a child from the care of a parent or guardian, placing the child in temporary custody, and the social worker believes continued detention is necessary for the child's protection, the county CWS agency files a petition for detention and jurisdiction over the child with the juvenile court, and a hearing is scheduled. After hearing the evidence, the court can either dismiss the petition or declare the child a dependent of the court. During the hearing process, the parent or guardian and the child have the right to be represented by an attorney. The court will appoint an attorney for a parent or guardian who cannot afford one.

When a court declares someone a dependent child, it may allow the dependent child to remain at home and order that family maintenance services be provided, and may limit the control exercised by the child's parent or guardian. Alternatively, the court may order that a dependent child be removed from the custody of the parent or guardian, in which case state law requires the court to first consider placing the child with a parent who did not have custody when the abuse or neglect occurred. If a noncustodial parent is not an option, the court orders that the child's care, custody, control, and conduct be under the supervision of the county CWS agency. A social worker may place that dependent child, in order of priority, with relatives or in a foster home or other suitable community care facility such as a group home (see text box).

**Common Types of Out-of-Home Care in Child Welfare Services System by Order of Priority:**

- Noncustodial parent
- Relatives or extended family members
- Foster homes
- Group homes

Source: Social Services' regulations.

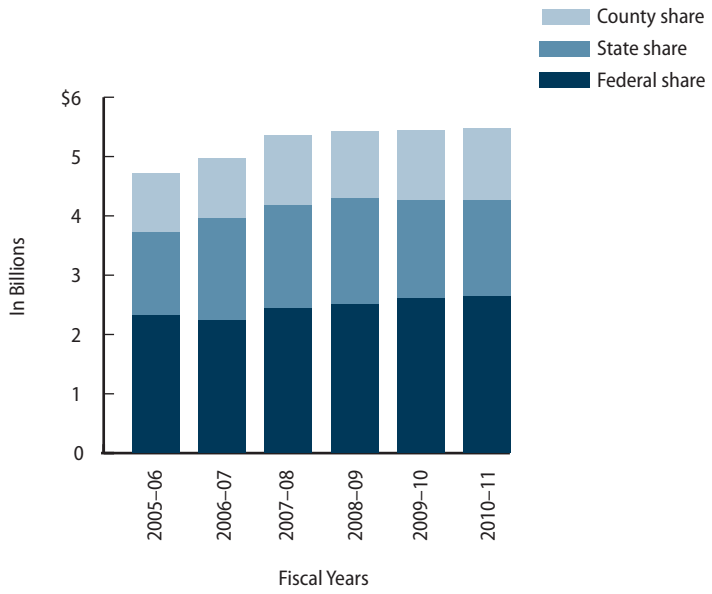
The county social worker and the family jointly develop a case plan to meet the needs of the family and address the safety concerns about the home environment. The CWS agency must provide permanent placement services for children who cannot safely live with their parents and are not likely to return home. The court may also dismiss a petition at any point if the issues that brought the family into court have been remedied and the child is no longer at risk.

### Funding for Child Welfare Services

Funding for child welfare services is a combination of federal, state and county resources. As indicated in Figure 3, systemwide funding has remained fairly steady for the last several fiscal years. The figure depicts the primary funding sources for the State's child welfare system, including the foster care and adoption programs. Historically, the State's share of CWS funding has primarily been paid out of the State's General Fund. However, as part of a new law called "2011 Realignment," a portion of state sales and use tax revenues and vehicle license fee revenues will be deposited into a separate

fund to pay for various CWS activities. According to the chief of Social Services' financial analysis bureau, this action eliminates certain CWS budget items from the General Fund budget.

**Figure 3**
**Child Welfare Services Budget**
**Fiscal Years 2005–06 Through 2010–11**




Source: Appropriation tables from the Department of Social Services (Social Services).

Note: Budgeted amounts reflect unaudited estimates from Social Services. The federal, state, and county shares are based on approved funding ratios and do not reflect the effects of any additional money budgeted by counties.

## Scope and Methodology

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to review one child protective services program in each of the State's four regions: Northern California, Bay Area, Central California, and Southern California. We selected for examination Sacramento, Alameda, Fresno, and Los Angeles counties, based on factors including size, population, geography, and number of allegations.[2] The audit committee also asked us to examine Social Services' role in providing counties with guidance and assistance and monitoring counties' compliance with applicable policies and procedures.

[2] Because Los Angeles refused to grant us access to certain records that are necessary for our audit but that it believed were not subject to our access authority, our audit work in Los Angeles was delayed. This report only includes information on Sacramento, Alameda, and Fresno counties. We disagree with Los Angeles and are undertaking additional efforts to obtain those records. We will issue a separate audit report on Los Angeles County at a later time.

The audit committee asked us to review policies and procedures designed to protect children from abuse at the counties we visited, especially those aimed at ensuring that a child is not placed in the custody of an inappropriate foster parent. Specifically, it asked us to review a sample of children in foster care to determine whether agencies followed placement policies and procedures and to determine whether children were removed from any inappropriate foster homes in a timely manner. We were also asked to identify the total number of reports of abuse or neglect for the counties we visited, the disposition of those reports, and the amount of time it took county staff to visit and make contact with the subjects of the reports for the most recent three years for which data was available. In addition, we were asked to review each county's policies and procedures related to visiting children's residences and to determine whether the counties were in compliance with their own policies and procedures as well as state law.

The audit committee also directed us to review information from the most recent three years on deaths of children who were in each county's CWS system, including the total number of deaths, the cause of death, demographic information on the children, and a description of the person caring for the child at the time of death. Further, we were asked to determine the number of deaths in homes that county CWS staff found to be inappropriate placements and whether any of those placements were in licensed facilities with a history of complaints. We were also asked to determine the number of children with reports of neglect or abuse on file within the two years prior to death and the timing of those reports relative to their deaths. We were asked to identify the number of children with open cases and the number with closed cases at the time of death. The audit committee also directed us to verify whether, subsequent to a child's death, individual counties performed a self-evaluation. If a county performed no self-evaluation, we were asked to determine whether it complied with policies, procedures, best practices, and laws prior to the child's death.

The audit committee asked us to identify the major categories of CWS expenditures for the past five years in the counties we visited, as well as the caseload per social worker during the same period, and compare the caseload ratio with available standards. The audit committee also asked us to determine the extent to which the counties have measured the impact any budget reductions have had on their ability to provide services and what adjustments they have made in response to budget reductions. Finally, the audit committee directed us to identify any best practices and to review and assess any other issues that are significant to counties' efforts to prevent child abuse and neglect.

To examine Social Services' oversight of the CWS system, we analyzed its monitoring role as defined in statute and interviewed department officials and select county CWS staff. We identified and evaluated the key monitoring mechanism of Social Services' family services division—the outcome review described in Chapter 3—as well as the ongoing licensing reviews conducted by its licensing division. We found that Social Services does not perform an address comparison of licensed facilities and CWS placements and the Department of Justice's (Justice) Sex and Arson Registry. Therefore, we performed this comparison and report the results in Chapter 1.

To determine the extent to which county CWS agencies ensure that a child is not placed in the custody of an inappropriate foster parent, we reviewed state regulations and each county's policies and procedures and tested 20 placements (eight placements in licensed foster homes and 12 placements with relatives or extended family members). To evaluate timeliness in removing those children from inappropriate foster homes, we reviewed 20 instances for each county in which a child was removed from placement. To determine the total number of reports of neglect or abuse in each county we visited, the disposition of those reports, and the timeliness of counties' CWS staff in visiting and making contact with the subjects of reports, we obtained and analyzed data from Social Services' CWS/CMS, and also reviewed 30 initial visits for compliance with counties' policies and procedures and state regulations.[3] To review and assess each county's compliance with its policies and procedures and state regulations related to ongoing cases, we analyzed another 30 cases that required ongoing case management visits.

To review information on deaths of children in the counties' CWS systems, we primarily obtained and analyzed records from Social Services related to child abuse or neglect fatalities, as well as information from CWS/CMS. To determine whether, subsequent to a child's death, the county performed a self-evaluation, we interviewed county officials and obtained internal county documents relating to child deaths. To the extent that counties did not conduct such self-evaluations, we determined whether they missed opportunities to learn from child deaths.

[3] A small percentage of children in the CWS system are on probation and are included in CWS/CMS. At times, case management activities for these children are performed by county probation departments and not by the county CWS agencies, which are the focus of our audit. However, because county CWS agencies sometimes are responsible for activities and decisions related to children on probation, and because they only represented 3 percent of the cases in the database, we left them in certain analyses performed in response to our audit objectives.

Documents from children's case files are generally confidential under state law; however, when a child dies from abuse or neglect, Senate Bill 39 of 2007 (SB 39) and its implementing regulations require the disclosure of the following information related to the deceased child:

- The age, gender, and date of death.
- The residence (whether the child was in parents' care, foster care, or the home of a guardian) at time of death and whether an investigation by law enforcement or the CWS agency is being conducted.
- All previous referrals and any reports shared by law enforcement.
- Any risk and safety assessments.[4]
- All health care records (except mental health) and police reports about the substantiated perpetrator.

**One Purpose of Senate Bill 39**

"Providing public access to juvenile case files in cases where a child fatality occurs as a result of abuse or neglect will promote public scrutiny and an informed debate of the circumstances that led to the fatality thereby promoting the development of child protection policies, procedures, practices, and strategies that will reduce or avoid future child deaths and injuries."

Source: Senate Bill 39 of 2007, section 1, legislative findings and declarations.

In our review of child deaths, we found this information in specific documents. To promote the development of better child protection policies and practices—which is one purpose of SB 39 (as indicated in the text box)—we summarize the actions of CWS agencies using some information from documents that are not fully accessible to the public (for example, investigative narratives and logs of delivered services). In such instances, we have removed details that would identify the families but would not be critical in analyzing the actions of the CWS agency.

To determine major categories of expenditures for CWS programs at the three counties for the past five years, we obtained expenditure records from county expense claims. We then verified that each county's administrator and auditor certified the accuracy of the expense claims. To determine amounts spent on out-of-home placements, we obtained summary reports of assistance expenditures to calculate these amounts, and compared them to certification letters signed by the counties' auditors. To determine the extent to which the counties have measured the

[4] Social Services regulations define the risk and safety assessments not merely as documents bearing these particular titles but as all documented information collected from the child(ren), caregiver, or collateral support persons that evaluates the protective capacity of the caregiver, any likelihood of future maltreatment, and whether there are present or imminent dangers to a child.

impact any budget reductions have had on their ability to provide services and what adjustments the counties have made in response to any budget reductions, we interviewed county officials.

To determine the cases per social worker, we used data from the CWS/CMS to calculate an average caseload for the three counties we visited. To determine the number of cases a social worker held, we identified the county worker with primary assignment for either a case or a hotline call during the last month of each quarter between 2006 and 2010. We only included those cases that had a service requirement. To calculate the effective number of cases a county worker held, we counted the number of days a county worker held a case and then divided it by the number of days in the month. This method allowed us to avoid errors, such as double counting cases that are transferred from one county worker to another during a month, and allowed us to give appropriate weight to cases held for only a few days in a month. To calculate the number of hotline calls, we determined the number of calls received by the counties during each month measured. To account for county workers who have cases in multiple service components, where each service component has its own standard, we prorated our counting of county workers using estimates of their time spent on each type of case based on a workload measurement and analysis report completed in April 2000, known as the *SB 2030 Study*. While these estimates were developed over a decade ago, they are the most recently published workload measurements. We excluded certain county workers such as clerks, office assistants, or supervisors who were assigned to cases but who are not assigned a regular caseload. Finally, for each service component, we summed the effective number of cases and then divided by our calculated number of prorated county workers to arrive at a county caseload average.

To address several of the audit objectives approved by the audit committee, we relied on computer-processed data provided by Social Services and Justice. The U.S. Government Accountability Office, whose standards we follow, requires us to assess the sufficiency and appropriateness of computer-processed information. To comply with this standard, we assessed each system separately according to the purpose for which we used the data in this report.

We assessed the reliability of Social Services' CWS/CMS for the purpose of sampling active cases, placements, and inappropriate placements, calculating the number of days between a report of abuse or neglect and a caseworker's visit, and the counties' workload. We identified no issues while performing data-set verification procedures and conducting electronic testing of key data elements of CWS/CMS.

To assess the completeness of key tables and fields within CWS/CMS, we would normally pull a haphazard sample of records related to key tables and fields used in our analysis. However, because not all 58 counties maintain paper case files and those that do are located throughout the State, we determined that this testing was not feasible. Instead, we haphazardly selected a sample of 29 case files from the four counties we visited. We tested these clients against CWS/CMS and found no errors. Additionally, Social Services informed us that CWS/CMS contains incomplete placement and case data from 1995 through part of 1998. In 1997 Social Services' new CWS/CMS was operational statewide and in June 1998 the final rollout and conversion activities were completed. Social Services and counties generally converted only those cases that were open during the conversion period. Cases that were closed prior to the CWS/CMS data conversion are not captured in the system.

To assess the accuracy of the key fields we used in our analysis, we pulled a sample of records from CWS/CMS. This sample contained records from 21 of the 58 counties. We then contacted four of these counties to determine what documentation would be available to support these fields and found these counties maintained inconsistent documentation. Based on our testing and analysis, we found that CWS/CMS is of undetermined reliability for the purpose of sampling active cases, placements, and inappropriate placements, calculating the number of days between a report of abuse or neglect and a caseworker's visit, and the counties' workload.

Further, for the purpose of identifying possible matches between addresses of registered sex offenders and the addresses of state- and county-licensed facilities, such as foster family homes, family day care homes, and adult residential facilities, we acquired the sex offender registry from Justice and Social Services' Licensing Information System (LIS). We assessed the reliability of the sex offender registry by conducting data-set verification procedures and performing electronic testing of key data elements. We identified no issues when performing data-set verification procedures, but during electronic logic testing of key data elements, we noted that some address data fields were blank nearly 42 percent of the time. Justice informed us that these blanks are likely due to the fact that the registry is populated by data entered by over 500 agencies. Nevertheless, we decided to conduct an analysis using the available address data since it is the best available source of this information. We determined that conducting accuracy and completeness testing for the sex offender registry was not feasible because the documentation supporting this data is located at over 500 agencies throughout the State; therefore, the data obtained from Justice's

sex offender registry is of undetermined reliability for purposes of identifying possible address matches between registered sex offenders and state- and county-licensed facilities.

We also assessed the reliability of Social Services' LIS data for identifying potential matches with Justice's sex offender registry by conducting data-set verification procedures, conducting electronic testing of key data elements, and attempting to conduct accuracy testing. We did not test the completeness of the LIS data because source documents required for this testing are stored in multiple district offices within the 58 counties throughout the State. We identified no issues when performing data-set verification procedures or electronic logic testing of key data elements.

To assess the accuracy of the data, we randomly selected 29 records from the LIS data file and conducted a test to determine whether we could match the data in those records to source documents. We were unable to obtain sufficient source documentation from Social Services to conduct these tests; therefore, we were unable to test the accuracy of the LIS. Thus, we found the data obtained from the LIS to be of undetermined reliability for the purpose of identifying potential matches with Justice's sex offender registry.

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# Chapter 1

## THE STATE COULD DO MORE TO MAKE SURE FOSTER CHILDREN ARE PLACED ONLY IN SAFE HOMES

### Chapter Summary

Despite a 2008 audit recommendation made by our office,[5] the Department of Social Services (Social Services) does not use the Department of Justice's (Justice) Sex and Arson Registry (sex offender registry) to identify sex offenders who may be inappropriately living or working in its licensed facilities or in the homes of foster children. When we compared the addresses of individuals in the sex offender registry with addresses of Social Services' and counties' licensed facilities and foster homes, we found over 1,000 address matches, nearly 600 of which are considered to be high risk.[6] We provided these address matches to Social Services and, after conducting investigations, it found registered sex offenders inappropriately living or present in several foster homes and other licensed facilities.

Social Services' regular oversight mechanisms—five-year reviews of all state-licensed facilities and regular reviews of counties' licensing activities—are beginning to lag behind statutory requirements and department goals. Social Services indicates that the reason for these trends, and the reason for not implementing an automated sex offender address comparison, is a lack of resources. For their part, the county child welfare services (CWS) agencies we visited generally completed required inspections and background checks on foster homes they license or approve and on individuals residing in those homes. They also removed children quickly, in most instances, if the home was found to be inappropriate. However, these agencies could improve on their follow-up on foster homes from which they removed children by more consistently notifying Social Services' Community Care Licensing Division (licensing division) of allegations, when applicable, and by submitting required reports to Justice.

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5 *Sex Offender Placement: State Laws Are Not Always Clear, and No One Formally Assesses the Impact Sex Offender Placement Has on Local Communities,* Report 2007-115, April 2008.

6 With input from Social Services, we categorized these address matches as high risk because a sex offender registering at the address did not appear reasonable given the purpose of the facility or home and because, if the address match proves correct, the situation poses an immediate threat to a vulnerable person.

### Social Services Is Not Using All Available Information to Determine Whether Sex Offenders Are Residing or Working in Child Facilities or Foster Homes

To ensure that registered sex offenders are not residing in licensed facilities that serve children, we recommended in a report issued in April 2008 that Justice and Social Services work together to allow Social Services access to Justice's sex offender registry. The purpose of Social Services gaining access to the database was to compare sex offender addresses with the addresses of facilities it licenses. Although Justice granted Social Services access to the sex offender registry, Social Services has not performed these comparisons because it did not get the resources that it felt were necessary to perform address comparisons and to follow up on the results. As discussed in the next section, Social Services implemented other measures, including checking the Megan's Law Web site[7] before it issues licenses, but none of these measures are a substitute for a full address comparison of all registrants in Justice's sex offender registry.

*We found over 1,000 total sex offender addresses that matched the address of a facility licensed by Social Services or a home of a child in the CWS system.*

Because Social Services had not performed its own automated address comparison, we felt we needed to compare sex offender addresses across all types of facilities licensed by Social Services and county CWS agencies. Our analysis included children placed outside their home—in foster or group homes, with guardians or relatives—as well as adults in licensed facilities. As indicated by Table 1, we found over 1,000 total address matches, roughly 600 of which Social Services agreed were a high risk and therefore required immediate follow-up. Of these high-risk matches, 95 percent pertain to the placement of children.

In July 2011 our office provided Social Services the information necessary for them to investigate and take appropriate action on the address matches summarized in Table 1. In October 2011 Social Services stated it had completed over 800 investigations and county CWS agencies had completed nearly 250 investigations. Social Services indicated that it began legal actions against eight licensees (four temporary suspension orders and four license revocations) and issued 36 immediate exclusion orders barring individuals from licensed facilities. In six of the eight legal actions, Social Services found registered sex offenders living or present in licensed facilities. The department stated it issued the immediate exclusions for several reasons, including a sex offender owning the property, a

[7] The Megan's Law Web site is the publicly viewable portion of Justice's sex offender registry.

sex offender's spouse being the licensee, a sex offender living at a licensee's personal residence, and a sex offender picking up mail at the facility.

**Table 1**
**Number of Sex Offender Addresses That Match Those of Licensed or Approved Facilities and Foster Homes**

| | SEX OFFENDERS' ADDRESS TYPES | | | | | | |
|---|---|---|---|---|---|---|---|
| FACILITY OR PLACEMENT TYPE | CAMPUS | ASSOCIATE | MAILING ADDRESS | NEXT OF KIN | BUSINESS | RESIDENTIAL | TOTAL MATCHES |
| State-licensed facilities for children | 9 | 19 | 10 | 24 | 146 | 180 | 388 |
| County-licensed facilities for children | | 2 | 4 | 7 | 3 | 38 | 54 |
| Homes of children placed in foster care | | 8 | 12 | 21 | 6 | 188 | 235 |
| State-licensed facilities for adults | | 3 | 9 | 13 | 31 | 329 | 385 |
| **Totals** | **9** | **32** | **35** | **65** | **186** | **735** | **1,062** |

| | BUSINESS | RESIDENTIAL | TOTAL |
|---|---|---|---|
| **High-Risk Matches** | **186** | **406** | **592** |

Sources: Bureau of State Audits' analysis of Department of Justice's Sex and Arson Registry and Department of Social Services' Licensing Information System and Child Welfare Services/Case Management System.

Notes: This table does not include address matches for sex offenders whose status is listed as incarcerated, deported, out-of-state, or transient, or where apartment numbers could not be verified.

Our analysis attempted to account for the variety of ways in which an address can be entered into the databases—for example, First Street versus 1st St—but may not account for all address variations. Although we are certain that all of the 1,062 address matches are accurate, we are less sure that the count is complete.

Some address matches in this table relate to the same sex offender with multiple registered addresses, the same address with multiple types of licenses, or the same address match appearing in different types of database comparisons. After eliminating all types of duplicates, we still found over 900 unique sex offender names.

Risk Categories:

- **High:** A sex offender registered at this address does not seem reasonable; and if correct, poses an immediate threat to a vulnerable person. Action on these address matches is of highest priority.
- **Medium:** A sex offender registered at this address may be allowable; however, research on these address matches should be done to ensure that the offender does not pose a risk to a vulnerable person.
- **Low:** An address match in these categories is not confirmatory evidence that a sex offender has access to a vulnerable person. Research on these types of address matches is of lowest priority.

County CWS agencies conducted 248 investigations and found 36 registered sex offenders to have "some association" with foster homes. According to Social Services' director, county CWS agencies took direct actions in eight cases, including removing foster children from homes, ordering registered sex offenders out of homes, and discontinuing relative caregivers' participation in the Kinship Guardianship Assistance Payment (Kin-GAP) program.[8] Additionally, county CWS agencies found eight cases in which

[8] The Kin-GAP program offers a subsidy for children who leave the juvenile court dependency system to live with a relative who has cared for the child for at least 12 months and is willing to assume legal guardianship of the child.

registered sex offenders were associated with foster homes but had no children living in the homes at this time. Of the 248 investigations, 15 resulted in the county agencies developing a safety plan where the registered sex offender was the "biological parent of a minor in the home or there was no condition placed by probation or parole to warrant removal of the child or ordering the [registered sex offender] out of the home." We believe these results highlight the importance of Social Services establishing mechanisms to begin performing this type of address comparison on a regular basis.

## Current Background Checks, Although Extensive, Do Not Eliminate All Safety Risks

Individuals seeking a license to operate a community care facility or others known to be living or working in licensed facilities or CWS placements must go through numerous types of background checks. Even so, individuals not known to be present during licensing or home approval, or who move into the home after these processes, may pose a threat to foster children. Before a child may be placed in a home, state law requires Social Services or county CWS agencies to ensure that the homes meet health and safety standards and that they will provide needed support. This evaluation includes background checks (see text box) for various individuals, depending on the type of facility where the child is placed. For placements in the home of a relative or extended family member, agencies must conduct a criminal records check on any person over 18 years old living in the home or having significant contact with the child, and may conduct this check on any person over 14 years old living in the home who the social worker believes may have a criminal record. For placements in licensed facilities, the licensing entity (Social Services or a county that has been delegated licensing authority) is required to conduct a criminal records check as part of the licensing process on the person who seeks the facility license and any other person, other than a client, residing or working in the facility.[9]

**Required and Other Potential Sources of Information for Background Checks:**

- State criminal records check by Department of Justice
- Federal criminal records check by Federal Bureau of Investigation
- Child Abuse Central Index
- Megan's Law Web site
- Child Welfare Services/Case Management System
- Local law enforcement records

Sources: California Health and Safety Code and Welfare and Institutions Codes; Department of Social Services' memo, and county policies.

[9] While California Health and Safety Code, Section 1522(b)(1)(B), requires a criminal records check on anyone other than a client residing in the facility, Social Services' regulations require such a check only on residents other than clients who are 18 years of age or older.

A specific name must generally be provided for a background check. However, the Megan's Law Web site can conduct address-specific searches. This type of search can identify certain registered sex offenders living in the home or facility who were not identified during, or who moved in after, the background check process.

After our April 2008 audit recommendation, Social Services implemented a requirement that its licensing analysts check the Megan's Law Web site against the facility addresses for new applicants. Social Services also modified its licensing database so it could include any sex offender information gathered by its analysts and allow management to verify that the required Megan's Law Web site check was completed. In addition, the department notified its licensees of the Megan's Law Web site and encouraged its use. Social Services disseminated similar information to county CWS agencies. In 2008 legislation was proposed requiring that county CWS agencies use the Web site before licensing a foster home or placing a child with a relative; however, the legislation was not enacted. As a potential result, the counties we visited were not consistent in their use of the Megan's Law Web site in their background check processes. Finally, in December 2008 Social Services submitted a budget change proposal requesting 30 positions ($3.5 million in the first year) to perform automated address comparisons using Justice's sex offender registry, to follow up on the results, and to investigate arrest reports for persons previously criminally cleared to operate or work at licensed facilities. Although the governor's proposed fiscal year 2009–10 budget included this proposal, it was ultimately rejected by the Legislature.

***The counties we visited were not consistent in their use of the Megan's Law Web site in their background check processes.***

The Megan's Law Web site does not provide the work addresses of sex offenders and provides the residency addresses of only a portion of registered sex offenders. Registered sex offenders may apply for exclusion from the Web site if their only registrable convictions are for certain sex offenses, such as lewd and lascivious acts with a child under 14 years old in certain circumstances, felony sexual battery, or misdemeanor child molestation. The Megan's Law Web site states that it excludes approximately 25 percent of registered sex offenders from public disclosure by law. Moreover, for the purpose of address-specific comparisons or checks, this Web site discloses only zip codes for numerous offenders. Taking exemptions and zip code-only offenders into account, the Megan's Law Web site displays the full California home address of less than half of registered sex offenders (approximately 56,000 of 125,000 registrants).

Conversely, Justice's sex offender registry includes the home and work addresses of all registered sex offenders. This database is available to law enforcement agencies, including Social Services' peace officers. The Megan's Law Web site checks performed

by Social Services' analysts and others are not a substitute for a comprehensive address-match analysis using Justice's sex offender registry. Furthermore, initial checks when a facility or home applies for a license do little to ensure that undisclosed adults do not move into the home later and pose a risk to children. Ongoing address comparisons, combined with vigilant enforcement of registration requirements, provide a mechanism for mitigating the risk that sex offenders are living or working among vulnerable foster children.[10]

### State Laws Could Be Strengthened to Ensure That Registered Sex Offenders Are Not Living at Licensed Child Facilities and Other CWS Placements

All adults living or working in licensed facilities and other potential placements for children in the CWS system (for example, homes of relatives or prospective guardians) must submit to background checks and would be prohibited from living or working in these locations if they have been convicted of a registrable sex offense. However, state laws could be strengthened to better ensure that registered sex offenders do not reside in children's facilities or CWS placements. If a background check reveals that a person has been convicted of a registrable sex offense, state laws, in effect, prohibit that person from receiving a foster child placement, receiving a license to operate a community care facility (for example, foster or group homes), living in a community care facility except as a client, and from being employed at a community care facility.[11] Registered sex offenders are not expressly prohibited from living in children's facilities or CWS placements similar to the residency prohibitions in Jessica's Law (see text box).

**Summary of Jessica's Law's Residency Restriction**

Registered sex offenders shall not reside within 2,000 feet of any public or private school, or park where children regularly gather.

Source: California Penal Code, Section 3003.5 (b).

If a registered sex offender is found improperly residing or working in a licensed facility or CWS placement, the facility or homeowner is required to expel the person

[10] Ongoing visits to foster children's homes by social workers (discussed in Chapter 3) are a critical element in keeping children safe. These visits, if done thoroughly and consistently, can also identify individuals posing a threat to children.

[11] Under state law, *conviction* is a term used in adult criminal proceedings (including when a juvenile is tried as an adult) but does not apply to juvenile court proceedings. Therefore, while state laws effectively prohibit a person who was convicted of a registrable sex offense from living or working in facilities where children are placed, these laws would not prohibit a person who is required to register as a sex offender as a result of a juvenile court proceeding from living or working in these facilities.

or face civil monetary penalties, misdemeanor criminal charges, or having the license or home approval revoked or suspended. However, the sex offender faces no consequences other than potential expulsion from the home or facility.

*If a registered sex offender is found improperly residing or working in a licensed facility or CWS placement, the sex offender faces no consequences other than potential expulsion from the home or facility.*

Social Services' regulations allow an adult friend or family member to visit a foster home licensee for a period up to one month without submitting to a background check, provided the adult is not left alone with a child. Therefore, a registered sex offender can currently visit a friend or family member who operates a foster home and stay there for up to one month without submitting to a criminal record review, provided he or she is not left alone with any children. Neither the registered sex offender nor the licensee would be in violation of the law in these instances.

Some local governments have ordinances prohibiting sex offenders from being within a certain distance of various facilities, such as daycare centers, schools, or playgrounds, or a place where children's activities are held. State law generally prohibits registered sex offenders who were convicted of a sex crime against a minor under the age of 16 from working directly with unaccompanied minor children. Nonetheless, state law allows registered sex offenders whose victims were 16 years of age or older to work directly with unaccompanied minor children as long as they disclose their status as registered sex offenders to their employers or volunteer organizations. Examining the collection of these laws and strengthening them where necessary is prudent, especially considering the results of the address comparisons described earlier.

### Social Services' Licensing Oversight Function Is Struggling to Complete Required Reviews and Inspections

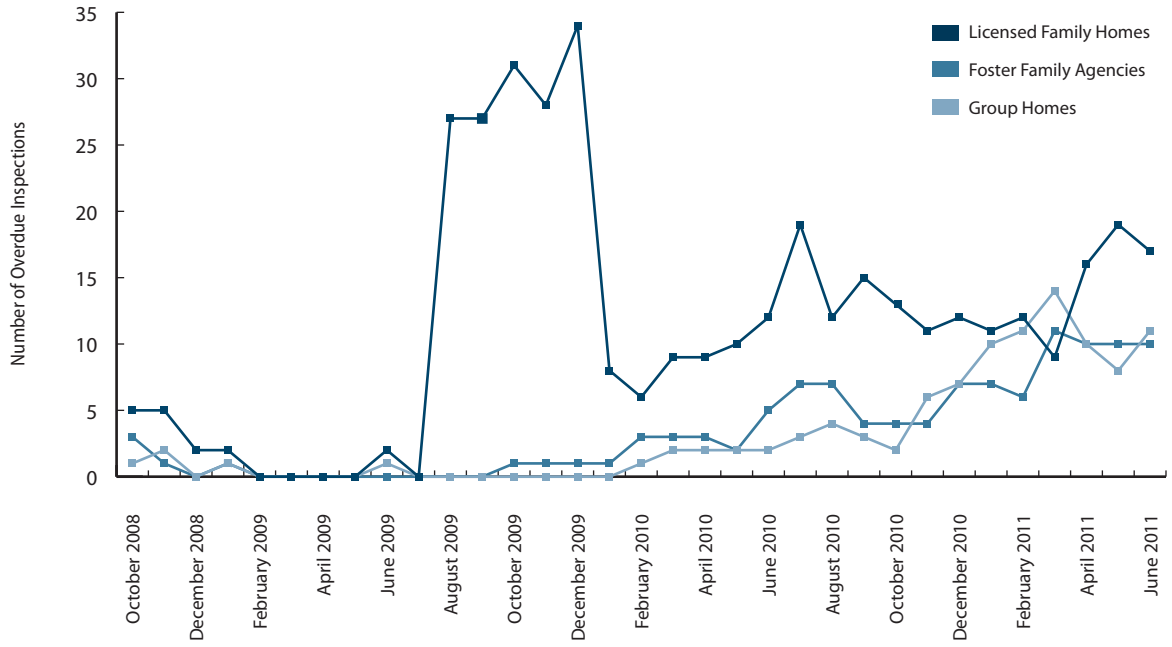
Resource constraints are straining Social Services' ability to oversee the out-of-home-care facilities it directly licenses and the licensing activities it delegates to county CWS agencies. Social Services has the authority to sign a contract with agencies to have them directly license foster homes. As of June 2011, 39 counties license foster homes under a delegation from Social Services. In the remaining 19 counties, Social Services' licensing division directly evaluate and license the foster homes. Social Services also licenses group homes, specialized treatment facilities, and foster family agencies.

Social Services' licensing division has a six-member unit (one manager and five analysts) that provides consultation and training to the 39 counties with licensing delegations. The five liaisons within this unit have a three-year schedule to perform comprehensive evaluations of county licensing activities (13 reviews per year). As part of the evaluation, the liaisons review

a sample of county licensing records to monitor compliance with licensing requirements. According to the program chief, the goal of visiting these counties once every three years was set internally and was based on what the department thought would be ideal in terms of monitoring compliance. However, she further stated that due to budgetary and resource constraints, the unit has been unable to achieve this goal in recent years. Our examination of the unit's report of completed reviews indicated it only completed six reviews in 2008, none in 2009, and three in 2010.

Community care facilities, such as group homes, specialized treatment facilities, foster family agencies, and state-licensed foster family homes are required to be visited by licensing division staff at least once every five years. As shown in Figure 4, the number of overdue five-year inspections has been increasing since the beginning of 2010.

**Figure 4**
**Number of Overdue Five-Year Inspections for Licensed Foster Homes, Group Homes, and Foster Family Agencies October 2008 Through June 2011**




Source: Unaudited monthly reports from the Department of Social Services' Community Care Licensing Division (licensing division).

Note: This figure only contains information from the licensing division for the 19 counties for which it is responsible and does not contain foster family home data from the 39 counties that have delegated licensing authority.

The dramatic August 2009 increase in the number of state-licensed foster homes overdue for an inspection depicted in the figure resulted from Mendocino County terminating its contract with

Social Services and transferring responsibility for foster home licensing back to the licensing division. Of the 27 foster family homes overdue for their five-year inspection in August 2009, 26 were from Mendocino County. The program administrator of the statewide children's residential program attributes the rest of the increases shown in Figure 4 to staff shortages primarily due to a hiring freeze and elimination of vacant staff positions.

In addition to five-year-visit requirements, Social Services is required to visit a random sample of facilities each year, and some facilities are inspected annually if they receive federal funds, or if they are on a corrective plan or probation, or when an accusation of wrongdoing is pending against the license holder. If a facility is not randomly selected or has not received a required annual inspection, it will be added automatically to the required five-year comprehensive inspection list. The licensing division produces a monthly management report to monitor all state-licensed foster family homes, foster family agencies, and group homes to determine if the facility has had its five-year comprehensive inspection.[12] It uses the report, which lists facilities due and those overdue for their comprehensive inspection, to prioritize facilities to visit.

In an October 2010 update posted on Social Services' Web site, the deputy director of the licensing division acknowledged that the division has been forced to prioritize work on all mandates as a result of the worsening budget situation. He indicated that the licensing division has reassessed its workload priorities to ensure the most significant health and safety activities are addressed. He further explained this does not mean that any mandated functions are completely suspended, but it does mean further delays will occur until licensing mandates are aligned with resources. As shown in the text box, the five-year inspections are currently a lower priority than some other functions.

**Community Care Licensing Division Workload in Order of Priorities**

1. Enforcement actions
2. Enforcement follow-up
3. Complaint inspections
4. Annual required inspections
5. Five-year inspections
6. Random inspections
7. Applications
8. Orientations
9. Appeals

Source: Department of Social Services' Web site.
Note: This list of the Community Care Licensing Division's workload priorities does not include its three-year evaluations of county licensing activities.

### The Three Counties We Visited Generally Fulfilled All Placement Requirements

We reviewed 60 placements—eight with licensed foster homes and 12 with relatives or extended family members (relative placements) at each of the three counties we visited—to ensure that required background checks and home

[12] Social Services' statistics indicate 5,000 of these types of facilities existed as of August 2011. Ostensibly, each year 1,000 of these facilities (80 per month) would be due for a five-year inspection.

inspections occurred. With few exceptions, we found that the counties fulfilled their responsibilities. Before receiving a child, foster homes must obtain the following:

- A license from Social Services or from a county with delegated licensing authority.
- Approval from a county CWS agency (for relative placements in particular) or certification from a foster family agency.

As indicated earlier, these preplacement activities include a home inspection and a criminal record check for the applicant and other specified individuals, such as other residents in the home. Should these individuals have a prior conviction, they can receive in some circumstances exemptions from either Social Services or officials within the county CWS agency.

Fresno, Alameda, and Sacramento counties each have delegated authority from Social Services to license foster homes. We reviewed 24 child placements with licensed foster homes (eight in each county), and found that the county CWS agencies generally performed all of the required checks and approvals before placing children in the homes. We found that the counties sometimes neglected to document required self-disclosure statements from individuals receiving background checks. Additionally, Alameda's CWS agency was unable to provide copies of background check documents in five instances because it could not locate the case folders. However, they were able to provide a checklist from CWS/CMS indicating the specific dates required background checks were performed. Despite these few deficiencies, agencies generally demonstrated diligence in the licensing duties delegated to them by Social Services.

As indicated earlier, relative placements must be approved by a county CWS agency. Requirements for relative placements are similar to those for licensed foster homes, except state law allows the county CWS agency to approve a family home after a check of the Child Abuse Central Index and a limited criminal background check on the relative and others living in the home, provided that a social worker submits fingerprints for a more comprehensive criminal background check within 10 calendar days of the initial criminal records check. In our review of 36 relative placements in Fresno, Alameda, and Sacramento counties (12 in each county), we found that the counties generally complied with home approval requirements. However, in one instance in Fresno, we found that the agency made an emergency relative placement but did not check the Child Abuse Central Index before placement and did not submit the relative's fingerprints to Justice until 29 days after the 10-day period specified in law.

The local law enforcement background check, performed for the initial placement, indicated a prior arrest for spousal abuse. The report from Justice, which the agency later received, indicated four additional arrests, including two more arrests for spousal abuse. However, because the relative had not been convicted of any of the alleged crimes, state law did not require an exemption for this individual. Even so, a Fresno official acknowledged the rapid placement of the child was done incorrectly because the criminal history should have been explored.

## County CWS Agencies Must Be More Vigilant and Responsive to Abuse and Neglect

For each of the three counties we visited, we reviewed 20 placement changes for children in the CWS system as a result of an allegation against the foster parent or a person living in the foster family home or aiding in the care of the child. When a social worker reasonably believes a child is in immediate need of medical care or is in immediate danger of physical or sexual abuse or the child's physical environment poses an immediate threat to the child's health or safety, state law authorizes the social worker to take into custody the dependent child (or a child a social worker reasonably believes may become a dependent child). We recognize that social workers must take into account a variety of factors before using this authority to remove a child from a CWS placement. We found that the agencies acted swiftly to remove children from unsafe situations in response to an allegation in most instances, based on our review of documents in the case file. However, in a few cases the agency did not appear to promptly remove the child from the home. We also found that county CWS agencies did not always take prudent, or at times required, follow-up actions to ensure that other oversight entities—Justice and Social Services' licensing division, in particular—were made aware of conditions leading up to the child's removal. Failure to report these instances of child abuse or neglect could result in a child being placed in an inappropriate home in the future because Social Services did not have the information to take necessary licensing actions or because Justice did not have complete information in its system.

***Based on our review of documents in the case file, the agency did not appear to promptly remove the child from the home in a few cases.***

### *Social Workers Did Not Always Remove Children From Inappropriate Placements in a Timely Manner*

Our evaluation of 60 foster home removals (20 at each county we visited) found that 46 were the result of formal referrals that county social workers evaluated and 14 came from a social worker's contact with children in placement. County social workers responded within the stipulated time frame in 44 of the 46 instances involving

***In most instances in which a child was not removed timely, the social worker was aware of problems with the home, yet did not remove the child either to maintain the child's placement with a relative or because no better options appeared available.***

formal referrals. For the remaining 14 complaints, agency staff did not assign a response time to informal complaints; therefore, we could not assess the response time for those cases. However, for all 60 cases we reviewed narratives in case files and, in a few instances, found early indications of problems that may have led to a more prompt removal. We noted in most of these instances the social worker was aware of problems with the home, yet did not remove the child either to maintain the child's placement with a relative or because no better options appeared available.

County social workers generally learn about abuse and neglect through formal reports to a 24-hour response system—called referrals—and through social workers' direct contact with children in placement. The county CWS agency staff person who receives a referral determines if an in-person investigation is necessary, and if so, how quickly a social worker must investigate the allegation—immediately or within 10 days. In one case in Sacramento, the alleged abuse seemed to call for an immediate response because a mandated reporter alleged physical abuse and described the child as nervous and scared. Although agency staff assigned a 10-day response to the referral, the assessment tool the staff person used to determine the correct response time frame indicated that a 24-hour response time was appropriate. However, the same staff person overrode that guidance and instead selected a 10-day response time. A social worker did not visit the child until 14 days after the initial referral, when she observed that the relatives' parenting methods were to control by intimidation and emotional/psychological abuse. Despite these findings and statements by the child that he was in danger, 10 more days passed before the agency removed the child from the home.

When we asked the agency why it did not remove the child from the home sooner, a division manager explained that although there were clear signs of emotional abuse and indications that corporal punishment occurred, the social worker did not believe the child was at risk of imminent physical abuse. In addition, the division manager stated that the child had been in other placements with poor outcomes, and since this was the only family the child had, the social worker was attempting to bring together all parties, such as school staff, to further assess placement options for the child. Although the agency substantiated emotional abuse in this instance, it indicated to the court roughly two months later that there was no allegation of emotional or psychological abuse in this case and recommended to the court that this child be returned to these same relatives. According to the division manager, the Sacramento County Adoption Agency was working with the relatives, as of August 2011, in moving forward with permanent placement of the child with the relatives. The division manager stated that the relatives completed 24 hours of training in areas including

understanding the dynamics of blended families and family communication, participated in family counseling, and signed and completed a corrective action plan.

### County CWS Agencies Must More Consistently Inform Oversight or Licensing Entities of Child Abuse and Neglect

Although Social Services' licensing division has not clarified when a county CWS agency should inform it of concerns with one of its licensees, we believe agencies should inform the licensing division of issues resulting in the removal of a child from a home licensed by the division. In one instance, a social worker in Fresno County became aware that a care provider in a home certified by a foster family agency had a criminal background. Discussions with the foster family agency called into question its diligence in performing the original background checks on the home. The social worker did not subsequently notify the licensing division of this issue. Fresno officials admit that they should have done so, and the county has revised its policies accordingly. Without clear direction from Social Services on what type of information it expects, the licensing division risks similar information breakdowns with other county CWS agencies.

***A social worker in Fresno County became aware that a foster family agency was not diligent in performing a criminal background check but did not subsequently notify Social Services' licensing division of this issue.***

Counties also do not always report abuse to Justice. State law requires county CWS agencies to notify Justice in writing of every case they investigate where known or suspected physical or emotional abuse or severe neglect are either substantiated or inconclusive.[13] Of the 60 cases we reviewed, 19 required a report to Justice. However, in 12 of these instances (nine in Sacramento alone) the agency failed to file the required report to Justice due to administrative oversight. In one instance, the Sacramento CWS agency investigated a referral of abuse against the relatives of a child. The agency substantiated emotional abuse, but evidence of physical abuse was inconclusive. The agency removed the child from the relative's home but did not report the abuse to Justice.

In an instance in Alameda County, a child claimed that a caregiver punched her. The agency substantiated physical abuse; however, it did not notify Justice of the abuse. A caregiver's history of abuse serves as information to agencies when they consider future placements of children. Without those warnings, oversight agencies are uninformed, and as a result, could expose more children to abuse.

[13] Chapter 468, Statutes of 2011, which takes effect in January 2012, requires that only substantiated cases of abuse and neglect be forwarded to Justice.

## Recommendations

To ensure that vulnerable individuals, including foster children, are safe from sex offenders, Social Services should complete follow-up on any remaining address matches our office provided in July 2011 and take appropriate actions, as well as relay information to Justice or local law enforcement for any sex offenders not in compliance with registration laws.

Social Services should begin to conduct regular address comparisons using Justice's sex offender registry and its Licensing Information System and CWS/CMS. If Social Services believes it needs additional resources to do so, it should justify and seek the appropriate level of funding. If efforts to obtain additional resources fail, Social Services should assign this high-priority task to existing staff.

To help keep children safe, the Legislature should consider enacting the following:

- A general prohibition of registered sex offenders living or working in licensed children's facilities or CWS placements.
- A requirement that all law enforcement staff overseeing sex offenders make sure that the addresses sex offenders submit for registration do not match a licensed facility for children or a foster home.
- A requirement that Social Services make available to law enforcement in an efficient manner the addresses of its children's facilities and foster homes.

To provide sufficient oversight of county CWS agencies with delegated authority to license foster homes, Social Services should complete comprehensive reviews of these agencies' licensing activities at least once every three years.

To ensure that its licensees, including state-licensed foster homes, foster family agencies, and group homes, are in compliance with applicable requirements and that children are protected, Social Services should complete on-site reviews at least once every five years as required by state law.

To encourage more effective communication from county CWS agencies regarding its licensees, Social Services should specify in regulations what types of situations or allegations the agencies should forward to its licensing division.

To ensure that county CWS agencies send required reports of abuse and neglect to Justice, Social Services should remind these agencies of applicable requirements and examine the feasibility of using CWS/CMS to track compliance with these statutory provisions.

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# Chapter 2

## UNABATED GROWTH IN PLACEMENTS WITH FOSTER FAMILY AGENCIES COSTS THE STATE MILLIONS

### Chapter Summary

The use of foster family agencies—typically private nonprofit organizations that recruit and certify foster homes—has increased from 18 percent to 29 percent in the last 12 years. We estimate that the growth in the percentage of placements with foster family agencies, which have dramatically higher rates than licensed foster homes, has resulted in spending an additional $327 million in foster care payments between 2001 and 2010—costing an additional $61 million in 2010 alone. The payment rates of foster family agencies, which are overseen by the Department of Social Services (Social Services), assume that children placed with these agencies will have elevated treatment needs that would otherwise land the children in even more expensive group homes. Despite these rate-development assumptions, Social Services does not require county child welfare services (CWS) agencies to document the treatment needs of children placed with foster family agencies. In fact, officials in counties we visited acknowledged that children without elevated treatment needs are being placed with foster family agencies, adding that treatment needs are only one factor causing such placements; other factors are the ability to take in large sibling groups, scarcity of licensed foster homes, and off-hour placement convenience.

### Regulations Require No Justification for Placing Children With Foster Family Agencies Despite Dramatic Rate Differences

Although the payment rate of foster family agencies is more than double that of state- or county-licensed foster homes, Social Services' regulations do not require county CWS agencies to document their justification for placing children with the more expensive agencies. County agencies are generally responsible for the placement of children within the CWS system. As a condition of receiving federal funding, federal law generally requires these children to be placed in the least-restrictive, most family-like environment possible. To keep children in these environments, Social Services' regulations require agencies to attempt to place children in the following priority order:

- Home of the child's noncustodial parent, relatives, or extended family members.
- Licensed foster homes or homes certified by foster family agencies.

- Group homes.
- Specialized treatment facilities.

For placements in group homes and specialized treatment facilities, Social Services requires a written justification in the child's case plan. Social Services' regulations place licensed foster homes and homes certified by foster family agencies on the same priority level and, even though the rate difference is dramatic, require no additional justification for placements with foster family agencies. As indicated in Table 2, prior to the 2011 rate increases primarily resulting from a lawsuit,[14] the monthly amounts paid to foster family agencies for children in their care was approximately $1,000 higher than for licensed foster homes.

**Table 2**
**Comparison of Monthly Rates for Licensed Foster Homes and Foster Family Agencies**

| | | | FOSTER FAMILY AGENCY TREATMENT RATES* (EFFECTIVE OCTOBER 2009) | | | |
|---|---|---|---|---|---|---|
| AGE GROUPS | LICENSED FOSTER HOME† (EFFECTIVE JANUARY 2008) | LICENSED FOSTER HOME (EFFECTIVE JULY 2011) | PAYMENT TO FOSTER HOME | ADDITIONAL SOCIAL WORK SERVICES | ADMINISTRATION | FOSTER FAMILY AGENCY TOTAL |
| 0–4 | $446 | $621 | $562 | $296 | $572 | $1,430 |
| 5–8 | 485 | 673 | 594 | 296 | 593 | 1,483 |
| 9–11 | 519 | 708 | 620 | 296 | 611 | 1,527 |
| 12–14 | 573 | 741 | 669 | 296 | 643 | 1,608 |
| 15–19 | 627 | 776 | 711 | 296 | 672 | 1,679 |

Source: Department of Social Services' (Social Services) letters to counties.

Note: Table does not include additional payments, such as specialized care increments for licensed foster homes and intensive treatment program rates for foster family agencies. Based on data from Social Services' estimates branch, the total estimated monthly payment per child to licensed foster homes averaged $754 and foster family agencies averaged $1,643 for fiscal year 2010–11. These amounts do not reflect payments from the two counties participating in the federal demonstration project described in Appendix A.

* Although state law requires Social Services to establish nontreatment rates, Social Services indicates that treatment rates are the predominant rates foster family agencies apply for and receive.

† Before July 2011 the rates for licensed foster homes in Los Angeles, Orange, Marin, and Santa Clara counties were slightly higher than the other 54 county rates reflected here. Also, counties may pay higher rates to licensed foster homes but must do so from county funds.

While payments to foster family agencies include a stipend for the foster home itself and for social work services, the majority of the increased cost—compared to licensed foster homes—is the 40 percent fee paid to the agency on a monthly basis for recruitment, training, and other administration (administrative fee).

[14] In December 2008 plaintiffs representing foster parents successfully challenged Social Services' foster care rates. Social Services had researchers from the University of California, Davis, conduct a rate study and, upon finishing the study, submitted to the court new rates in April 2011. These new rates went into effect in May 2011 and then received a cost-of-living adjustment in July 2011.

Social Services' chief of the foster care rates bureau (rates chief) indicated that the administrative fee was developed before she held her position and that she could not locate any support for the figure. The rates chief provided us a study (phase one of which is quoted in the text box) that indicates the foster family agency rate structure was developed at least 10 years ago. The second phase of this study, which was prepared by the University of California, Davis, and published in June 2001 (UC Davis study), recommended that the cost of using foster family agencies versus licensed foster homes be examined. However, this type of examination does not appear to have ever occurred.

> "Originally, FFAs [foster family agencies] were developed as an alternative placement to group homes, but as time has passed FFAs have become an alternative placement to FFHs [foster family homes]".
>
> Source: Department of Social Services, *Report to the Legislature, Children Placed in Foster Family Agencies and Non-Relative Foster Family Homes*, June 2000.

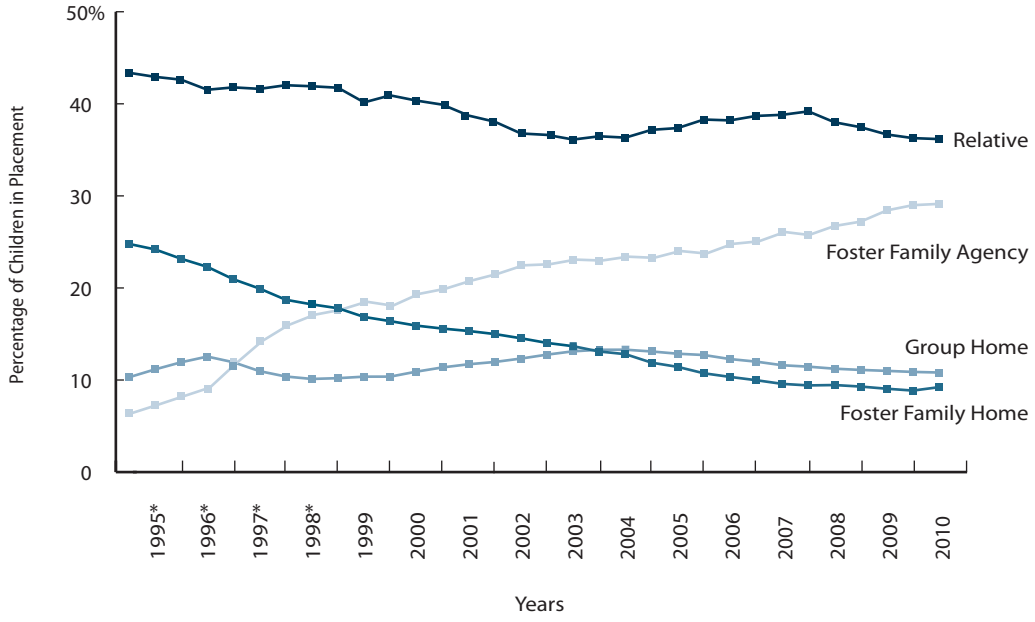
According to the rate-setting regulations associated with foster family agencies, the rates are intended to be for children with elevated treatment needs, which the regulations specify as meaning the placement agency has determined that the child has needs that cannot be provided in an available family home and would require placement in a group home if not for the existence of foster family agencies' treatment programs. However, Social Services' placement regulations do not require documentation of a determination that children have elevated treatment needs before placing them with higher-cost foster family agencies. The rates chief believes that county CWS agencies need to demonstrate the elevated treatment needs of children placed with foster family agencies. Nevertheless, the Social Services' official overseeing placements confirmed that county CWS agencies are not required by the regulations governing placement to document these decisions. Therefore, the difference between the rate-setting assumptions and the placement requirements county CWS agencies are to follow reveals not only a regulatory disconnect but also a failure of two functions within Social Services to effectively communicate.

### County CWS Agencies Have Not Required Social Workers to Document Why Children Are Placed With Foster Family Agencies

While two of the county CWS agencies we visited have recently documented policies that prioritize licensed foster homes over foster family agencies, none required a written justification or supervisor approval for placing children with a foster family agency during the period of our review. Each of the agencies we visited stated that its preference was to place children with licensed foster homes before foster family agencies; yet in practice, a lack of licensed foster homes and the convenience of using these agencies has resulted in increased foster family agency placements. As indicated in Figure 5 on the following page, placements in foster family agencies have increased from 18 percent in 1999 to 29 percent in 2010.

Rather than a precipitous decrease in the percentage of group home use, the greatest percentage decrease over this time period has been in the use of licensed foster homes.

**Figure 5**
**Percentage of Children in Placement by Type**
**1995 Through 2010**




Source: Bureau of State Audits' analysis of data obtained from Department of Social Services' (Social Services) Child Welfare Services/Case Management System (CWS/CMS).

Note: The figure displays the four major types of placements as a percentage of total placements. Other types of placements as a percentage of total placements, guardian homes being the most frequent, are not shown.

* Social Services indicates that, when data was converted from a previous case management system to CWS/CMS, cases that were closed prior to the conversion process were not brought into CWS/CMS. Consequently, CWS/CMS is incomplete for years 1995 through at least part of 1998. Social Services indicates that this incomplete data affects all placement types, especially those that tend to have shorter case lengths (relatives and foster family homes, in particular).

As discussed earlier, foster family agency homes received a higher monthly compensation rate than state- or county-licensed foster homes until July 2011. Officials from Alameda and Fresno counties indicate that this was one difficulty in recruiting licensed foster homes. Additionally, the administrative component of foster family agency rates provides funding for their recruitment efforts, while county efforts to recruit foster homes come from a funding pool that competes with numerous other priorities, including receiving and investigating complaints of abuse or neglect. Although CWS agency officials at the counties we visited stated their agencies prefer to use licensed foster homes, state law requires them to base selections of out-of-home placements on meeting the critical needs of the child, such as accommodating a language other than English,

continued attendance at his or her school, or being placed with siblings. A lack of licensed foster homes would make it even more difficult for counties to find a foster home that matches a particular child's needs.

Officials at Alameda and Fresno counties also described how using a foster family agency to locate a foster home match for a child can be easier. Not only are more agency homes available, but the foster family agencies also take responsibility for the mechanics of identifying a suitable home and for arranging the placement, thus relieving an administrative burden on the county CWS agency. Sacramento County CWS officials pointed out that some foster family agencies have specialized skills that benefit certain children, such as helping to facilitate family reunification or adoption. Having a foster family agency perform these functions removes one more administrative task from county CWS agencies.

Officials in Alameda and Fresno counties admitted that the culmination of past conditions and practices has resulted in children being placed in foster family agencies who do not have elevated treatment needs. A Fresno County official explained that there is often little distinction between children placed in one of its county-licensed foster homes and children placed with foster family agencies, adding that "placements are being directed towards foster family agencies that are more about convenience than treatment needs." The UC Davis study, which included a review of a sample of over 700 children in placement, corroborates these assertions; in fact, the study found that children in its sample of licensed foster homes had higher frequencies of medical, physical, behavioral, psychological, and learning problems than children in its sample of foster family agency homes. The 2001 UC Davis study concluded that foster family agencies "had morphed into something different than originally conceived."

As Figure 5 shows, in the years that have passed since the UC Davis study findings, the percentage of placements in foster family agencies has increased from 21 percent in July 2001 to 29 percent in July 2010. Over that time, Social Services has not examined the foster family agency rates and has not created a requirement that county CWS agencies document their justification for placements with these higher-cost agencies. We estimate that the growth in the percentage of placements with foster family agencies resulted in an additional $327 million in foster care payments between 2001 and 2010 ($61 million in 2010 alone).[15] If Social Services

***We estimate that the growth in the percentage of placements with foster family agencies resulted in an additional $327 million in foster care payments between 2001 and 2010 ($61 million in 2010 alone).***

[15] Our calculation is based on the average difference of roughly $1,000 between the estimated monthly payments per child to foster family agencies and licensed foster homes over the last six fiscal years. Those payments do not reflect payments to two counties while they were participating in a federal demonstration project described in Appendix A.

begins requiring a written justification for placements with foster family agencies, these types of placements may decline over time. As indicated by the next section, counties would have to modify some existing practices to reduce their reliance on foster family agencies, and doing so would likely require an investment of at least a portion of the amount that would otherwise be directed to these agencies. For example, for fiscal year 2010–11, Social Services allocated $2.4 million for foster parent training and recruitment. To reduce reliance on foster family agencies, this allocation may need to increase.

### Certain County Practices and Programs Facilitate Better Placement Decisions

The counties we visited have implemented some best practices that facilitate finding a relative or a licensed foster home placement. These efforts streamline the process of locating an appropriate placement, remove some of the time pressure that can lead to less-than-ideal decisions, and thus could reduce overreliance on foster family agencies. For example, to lessen the trauma of a child being removed from his or her home, and to expand the time Alameda County's CWS agency has to make a placement decision, it opened an assessment center in 2002. This center is a comfortable, child-friendly facility where children can rest and wait while staff identify a placement—as opposed to waiting in the back of a police car or at a police station. The assessment center, which is open 24 hours a day, gives Alameda staff additional time (up to 23 hours) to meet the child, convene a team decision-making meeting (described below), and make an informed placement decision.[16]

Beginning in July 2007 Alameda County's CWS agency also implemented a centralized placement unit, which is located at the same site as its assessment center. Before the placement process became centralized, individual social workers were responsible for initial placements. Particularly in off-hours and on weekends, social workers were often faced with difficult placement situations. In these instances, calling a single foster family agency was much easier than culling through county-licensed foster home lists and calling around to see if someone could take a placement. In contrast, the centralized placement unit and assessment center facilitates a team decision-making process for each child in its care. Alameda County's CWS agency indicates that it convenes a meeting

***In off-hours and on weekends, calling a single foster family agency was much easier than culling through county-licensed foster home lists and calling around to see if someone could take a placement.***

[16] Alameda County reports that the assessment center costs $3 million annually; however, half of this total relates to mental health services that children receive at the assessment center and that are at least partially reimbursed by Medi-Cal. In addition to CWS and Medi-Cal funds, Alameda County reports that it receives other state and federal money to run the center.

of key people in the child's life, such as relatives, community members, and social workers, to discuss placement options for the child and to make a team decision. The additional time for making a decision that the assessment center provides makes it possible to more consistently implement the team decision-making process. Alameda County believes this is one important component of its success in keeping relative placements high.

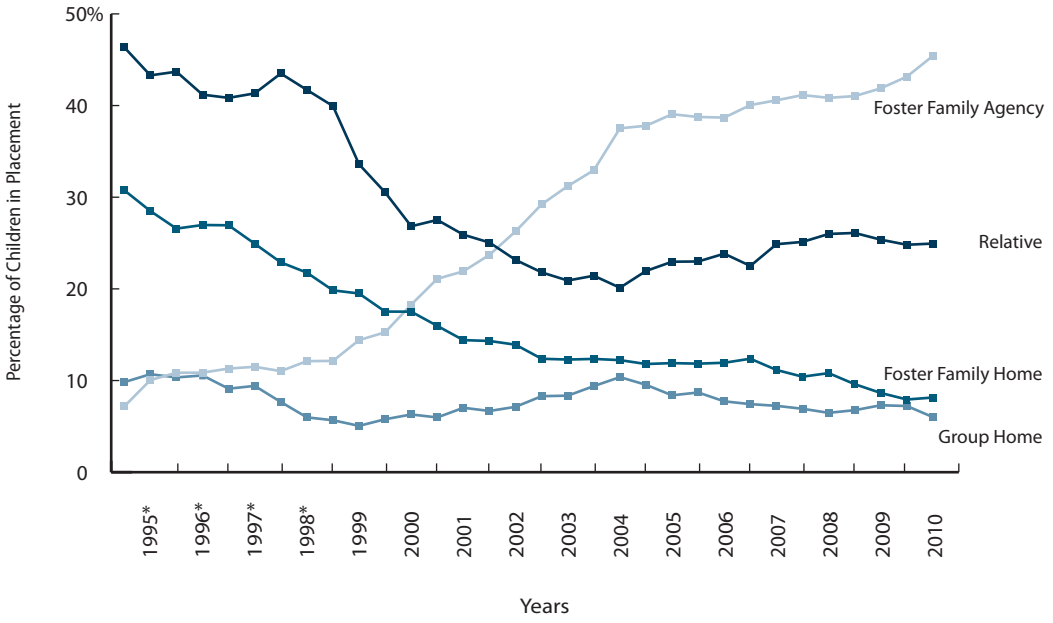
Counties we visited have also instituted new approaches for finding appropriate homes that take advantage of information technology and centralized processes. State law requires counties to first exhaust relative placement options before placing a child in a home other than that of a relative. According to an Alameda County official, his agency found that due to statutory requirements for relative home approvals, relative placements require significantly more work and time than placing a child with preapproved foster family agency homes or group homes. In 2005 Alameda implemented the Family Finding and Engagement Program, which invests more up-front effort into identifying and approving eligible-relative homes rather than placing children in other foster or group homes. The Family Finding and Engagement Program makes an exhaustive effort, through Internet searches, data-mining, and other sources, to find potential homes of relatives.

Sacramento County's CWS agency indicates that when relative placements were not an option, it began using a database in January 2011 to identify foster homes available for placement. The purpose of the database, which includes both county-licensed foster homes and foster family agency homes, is to enable placement staff to search for an available home based on child-specific criteria, such as the number of siblings, the school the child attends, and the child's neighborhood.

Fresno County does not have an assessment center, and placement decisions continue to be the responsibility of individual social workers. This may be one reason that placements with foster family agencies have greatly surpassed placements with relatives, as shown in Figure 6 on the following page. According to the deputy director of Fresno County's Department of Social Services, its CWS leadership, who were concerned about these results, created a resource unit that is developing tools to help social workers make placements with relatives and county-licensed foster homes before turning to foster family agencies. However, these efforts are in their infancy and do not appear to have yet had an effect on overall placement trends.

***Fresno County does not have an assessment center, and placement decisions continue to be the responsibility of individual social workers, which may be one reason that placements with foster family agencies have greatly surpassed relative placements.***

**Figure 6**
**Percentage of Fresno Children in Placement by Type**
**1995 Through 2010**




Source: Bureau of State Audits' analysis of data obtained from the Department of Social Services' (Social Services) Child Welfare Services/Case Management System.

Note: The figure displays percentages of total placements for the four major types of placements shown previously in Figure 5.

* As noted in Figure 5 on page 38, Social Services indicates that these years contain incomplete data.

## Recommendations

To ensure that rates paid to foster family agencies are appropriate, Social Services should analyze the rates and provide reasonable support for each component, especially the 40 percent administrative fee it currently pays these agencies. Additionally, Social Services should create and monitor compliance with clear requirements specifying that children placed with these agencies must have elevated treatment needs that would require a group home placement if not for the existence of these agencies' programs. At a minimum, Social Services should do the following:

- Revise its regulations so licensed foster homes have higher priority than foster family agencies for children that do not have identified treatment needs.

- Require county CWS agencies to file in the Child Welfare Services/Case Management System a detailed justification for any child placed with a foster family agency.

- Create a mechanism by which it can efficiently check for compliance with the needs-justification requirement.

To achieve greater cooperation from county CWS agencies and to make it possible for some of these agencies to improve their placement practices, Social Services should develop a funding alternative that allows the agencies to retain a portion of state funds they save as a result of reducing their reliance on foster family agencies and only making placements with these agencies when justified by the elevated treatment needs of the child. The agencies would use these funds to support placement activities necessary to achieve the savings (for example, assessment centers and placement resource units).

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# Chapter 3

## SOCIAL SERVICES HAS ESTABLISHED A MECHANISM FOR MONITORING KEY CHILD WELFARE OUTCOMES

### Chapter Summary

The Department of Social Services (Social Services) oversees county child welfare services (CWS) agencies by monitoring outcomes in the areas of safety, permanence, and child and family well-being. The efforts of Social Services and the county CWS agencies appear to have resulted in some improved compliance with investigatory and case management requirements. However, improvements in county CWS practices and in Social Services' measurements continue to be needed. A potential constraint on practice improvements is resources—the number of social workers in particular. A study conducted for the Legislature and published in 2000 recommended lower social worker caseload standards. Since that time, the number of children in the CWS system has decreased but, as a matter of state policy, funding levels for child welfare services have not received corresponding decreases. Although the purpose of this policy was to bring caseloads down, Social Services has not developed a consistent methodology for measuring the effect of this policy on caseloads. We believe Social Services could refine and use its Child Welfare Services/ Case Management System (CWS/CMS) to calculate and report caseload statistics.

### State Oversight of Child Welfare Investigations and Case Visits Appears Adequate

Social Services has created a set of requirements and measures that appear to be adequate in directing and monitoring the investigatory and ongoing case management activities of county CWS agencies. It issues and analyzes quarterly data reports that broadly measure the performance of the CWS system and also provide insight into agencies' compliance with case management requirements. Further, Social Services has created definitive goals for the CWS system and has implemented a formal review process to measure outcomes in the areas of safety, permanence, and child and family well-being. The efforts of Social Services and county CWS agencies appear to have resulted in some improved compliance with case management requirements statewide.

### *Social Services Established Specific Case Management Requirements for Child Welfare Services*

As indicated in the Introduction, the typical CWS process begins when a report of suspected child abuse or neglect (referral) is called into a county child abuse hotline. Regulations issued by Social Services require the hotline social worker (screener) to record all available and appropriate information and then to decide whether a referral warrants an in-person investigation. Decisions made by screeners must receive supervisory approval. For referrals that require an in-person investigation, state regulations require the investigation to occur either immediately or within 10 calendar days of the date the referral was received. During these in-person investigations, the social worker must have in-person contact with all the children alleged to be victims and at least one adult who has information regarding the allegations. Finally, the social worker generally must, within 30 calendar days of the initial in-person investigation, determine whether child welfare services are necessary; if so, the social worker creates a case plan, and if not, the social worker closes the referral.

Some counties require the screener to use a decision-making tool to determine what type of response a referral needs. Similarly, to assist the social worker conducting the investigation in determining whether child welfare services are necessary, some counties require that the social worker use initial safety and risk assessment tools. Although not specifically required, Social Services set a goal to increase the use of these decision-making and safety assessment tools.

When a county CWS agency determines that child welfare services are necessary, the agency will typically indicate in its records that the original referral has been closed and a case has been opened. Social Services' regulations generally require social workers to visit children at least three times in the first 30 calendar days, including the initial in-person investigatory response. Social workers must visit every child at least once each calendar month thereafter. Less frequent visits, or contact exceptions, are permitted in certain instances. For example, if the child is receiving permanent placement services, is in placement with a legal guardian, and is not a dependent, contact can be reduced to no less than once every six months. Social Services is developing regulatory changes that will eliminate many of these contact exceptions, based on new federal requirements that take effect in October 2011.

***Our review of child deaths underscores the importance of county CWS agencies properly assessing and investigating referrals.***

Our review of child deaths underscores the importance of county CWS agencies properly assessing and investigating referrals. The death of one child in Fresno County was preceded by several instances of the agency assessing and investigating referrals.

For one referral, the social worker determined that allegations of physical abuse were inconclusive, assessed the case as low risk, and closed the referral because the social worker could not determine who was the perpetrator, based on the available evidence. For a second referral on the same child, the agency decided not to investigate allegations, including that the child was verbally threatened. In a third referral, the reporting party allegedly could hear fighting coming from the home and was concerned that the child was being abused; the agency classified the referral as requiring a 10-day response. A fourth referral alleged that the child, among other factors, had multiple bruises. The agency classified this referral as requiring a response within 10 days. On the fourth referral the social worker then attempted to contact the family three times over a period of 46 days but was unsuccessful. Toward the end of this 46-day period, the agency received a fifth referral. As described on page 68, this referral—from a law enforcement agency—required a response. The agency employee receiving the new referral closed it and sent an e-mail to the social worker investigating the previous referral, notifying her of the new incident. According to Fresno's quality assurance program manager, the agency has since retrained its hotline staff on the use of its risk and safety assessment tools.

### *Social Services Uses Outcome Measures to Monitor County CWS Agencies' Performance*

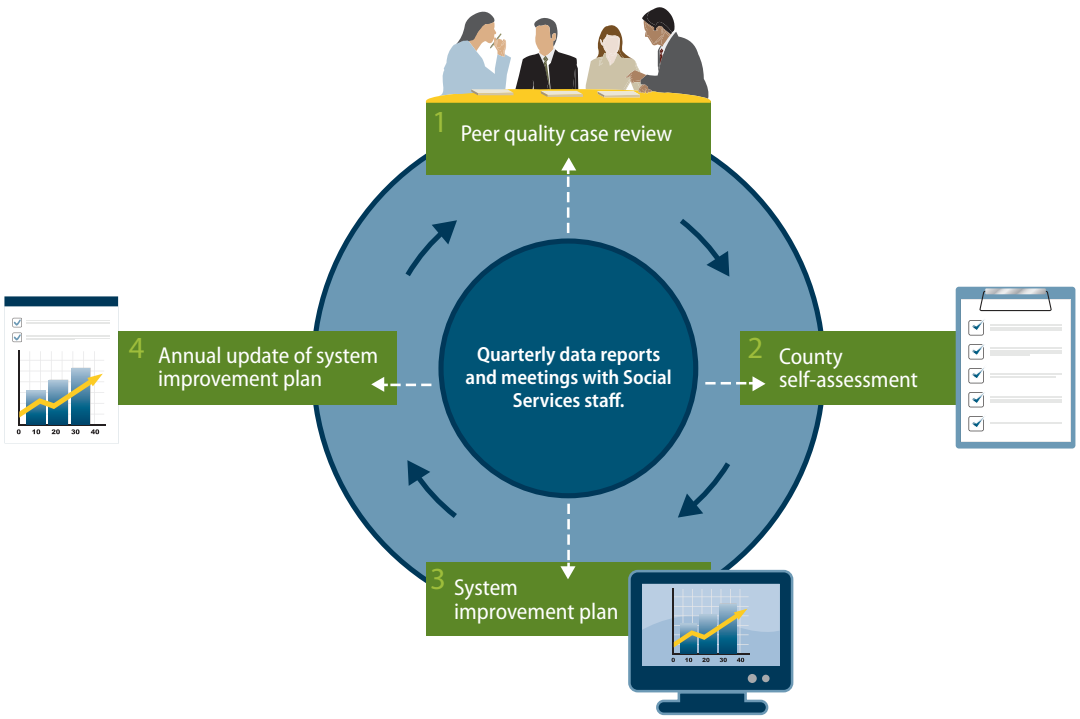
***In 2001 the Child Welfare System Improvement and Accountability Act was enacted to provide greater accountability for child and family outcomes in California's CWS system.***

In 2001 the Child Welfare System Improvement and Accountability Act was enacted to provide greater accountability for child and family outcomes in California's CWS system. This law required Social Services to establish the California Child and Family Service Review system (outcome review) to review all county CWS systems. The outcome review is the key mechanism Social Services currently uses to monitor the CWS system; it replaces the former oversight system, which Social Services indicated focused exclusively on regulatory compliance. The outcome review is a three-year cycle of regular activities focusing primarily on measuring outcomes in the areas of safety, permanence, and child and family well-being. Social Services has partnered with the University of California, Berkeley, to aggregate CWS data. This comprehensive data source allows those working at the county and state level to examine outcome measures over time.

As shown in Figure 7 on the following page, the outcome review begins with the peer quality case review (peer review), which requires a county CWS agency to bring in outside expertise, such as Social Services, peers from other CWS agencies, and community stakeholders to assess the strengths and needs of the county's CWS practices. The peer review is also intended to promote the exchange

of best practice ideas between the host county and peer reviewers. During the next phase of the outcome review cycle, the agency prepares a self-assessment based on analyses of child welfare data, input from various child welfare constituents, and its own review of child welfare and probation services provided within the county.

**Figure 7**
**California's Outcome Review Process**




Source: Department of Social Services' letters to counties describing the outcome review process.

The culmination of the peer review and self-assessment is a formal system improvement plan, which is an operational agreement between the county CWS agency and Social Services outlining how the agency will revise its practices to improve outcomes for children, youth, and families. The system improvement plan is due approximately one year after the peer review and requires approval by Social Services and the county's board of supervisors. One year after publication of the system improvement plan, Social Services requires an update report from the county CWS agency. This update provides stakeholders and Social Services with the status of the county's activities as well as any changes or modifications to the system improvement plan. Social Services provides technical assistance to counties throughout the outcome review process, including meeting quarterly with each county to discuss data

trends and progress. For five counties (the three that we visited plus two others randomly chosen), we confirmed through documents in Social Services' possession that the agencies are participating in the outcome review process outlined in Figure 7.

As indicated earlier, the focus of the outcome review is on measuring outcomes for children. Even so, certain compliance-related measures are built into the process, including timeliness of investigatory and ongoing case visits. Under its safety-related measures, Social Services established a target rate of 90 percent for compliance with the immediate and 10-day requirements for investigatory visits. Table 3 indicates that the State, on average, exceeded this goal over the last five years. However, as we discuss later, this measure is somewhat misleading because it includes attempted, not just completed, visits. We present statistics on completed visits only later in this chapter. Social Services also established 90 percent as its systemwide standard for compliance with the requirements associated with ongoing case visits, measured by the outcome review as well. As shown in Table 3, the State, on average, began to exceed its established goal in 2008.

**Table 3**
**Percentage of Timely Investigatory and Case Worker Visits**
**2006 Through 2010**

| | PERCENTAGE OF TIMELY INVESTIGATIONS BY TYPE | | PERCENTAGE OF ONGOING CASE VISITS COMPLETED ON TIME |
|---|---|---|---|
| YEAR | IMMEDIATE | 10-DAY | |
| 2006 | 97% | 91% | 83% |
| 2007 | 97 | 92 | 88 |
| 2008 | 97 | 94 | 91 |
| 2009 | 98 | 95 | 92 |
| 2010 | 98 | 94 | 92 |

Source: Unaudited data from child welfare services reports for California retrieved from the University of California at Berkeley Center for Social Services Research Web site.

Note: The percentages related to investigations shown in the table include attempted, as well as completed, visits.

While Social Services generally uses outcome measures to monitor the performance of county CWS agencies, it also reviewed a sample of 381 cases to evaluate the quality of visits with children in the CWS system. These online case reviews examine, for example, the location of the visit; whether the social worker interacted with the child alone; and whether the social worker addressed the child's needs, services, and case goals. Social Services indicated that it does not conduct these reviews on a regular schedule but that it performed them in fall 2009 and in spring 2011. Although we did not confirm these

results, Social Services indicated that in 2009 it found that social worker visits with children met its measures of quality in 83 percent of the cases it reviewed and that in 2011 this percentage improved to 86 percent.

## County CWS Agencies Can Improve the Timeliness of Their Investigations

We determined that the county CWS agencies typically followed state regulations and county policies but can improve their response time, completion of investigations, and adherence to other standards and best practices, based on a detailed review of 90 referrals (30 at each of the three counties we visited). Each county appears to be struggling to complete in-person 10-day investigatory visits in the required time frame. Furthermore, each of the three counties appeared to struggle in varying degrees to complete their investigations within 30 days, as required by regulations. Finally, we found that social workers do not consistently visit children at their residences.

### *County CWS Agencies Occasionally Missed Timelines for Response to Referrals*

As mentioned earlier, state regulations require in-person investigatory visits to occur either immediately or within 10 calendar days. As indicated in Table 4, the county CWS agencies we visited usually completed in-person investigative visits within required time frames. However, each county missed required deadlines in some instances. For example, the Sacramento County CWS agency missed 10-day deadlines for five of the 12 cases we reviewed. In one instance a Sacramento social worker was 67 days late in successfully completing an in-person visit in response to a 10-day referral alleging physical abuse of a child. The manager of Sacramento's emergency response division stated that the data they use to assess their performance indicate a higher level of compliance than the results from our review. However, those performance measures include attempted and completed visits, while Table 4 only includes completed visits.

**Table 4**
**Number of Timely Responses to Referrals**
**2008 Through 2010**

| | NUMBER OF TIMELY VISITS BY TYPE (NUMBER OF REFERRALS REVIEWED) | | |
|---|---|---|---|
| COUNTY | IMMEDIATE (18 REVIEWED) | WITHIN 10 DAYS (12 REVIEWED) | COMBINED TOTAL (30 REVIEWED) |
| Alameda | 17 | 8 | 25 |
| Fresno | 15 | 9 | 24 |
| Sacramento | 17 | 7 | 24 |

Source: Bureau of State Audits' analysis of 30 referrals at the three counties visited.

In most of the cases in Table 4 in which the social worker missed the deadline for completing the initial investigative visit, he or she made one or more attempts to see the child, but for reasons that may have been out of his or her direct control, did not successfully complete the visit in the required time frame. In only two of the 90 cases we reviewed (both in Alameda County) did a social worker fail to make an attempt to see the child during the required investigation time frame. Even so, measuring whether in-person investigatory visits are actually completed and not just attempted is critical because Social Services and county CWS agency management need to know if social workers are effectively conducting timely in-person observations and interviews of children who have allegedly been abused or neglected and of adults with information regarding such allegations. Social Services' outcome measures do not currently capture this information. Table 5 presents the percentage of investigatory visits completed timely, not including attempts, for the three counties we visited and also statewide.[17] As indicated in Table 5, statewide performance dipped in 2010 after four years of general improvement. Likewise, the three counties we visited generally experienced a decrease in performance in 2010.

**Table 5**
**Percentage of Completed Timely Investigatory Visits by County and Type 2006 Through 2010**

| | COUNTY | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | ALAMEDA | | FRESNO | | SACRAMENTO | | STATEWIDE | |
| YEAR | IMMEDIATE | 10 DAYS | IMMEDIATE | 10 DAYS | IMMEDIATE | 10 DAYS | IMMEDIATE | 10 DAYS |
| 2006 | 87% | 62% | 94% | 64% | 84% | 65% | 88% | 70% |
| 2007 | 88 | 67 | 92 | 56 | 87 | 64 | 88 | 70 |
| 2008 | 89 | 71 | 93 | 64 | 78 | 62 | 89 | 73 |
| 2009 | 88 | 67 | 94 | 63 | 88 | 70 | 91 | 73 |
| 2010 | 85 | 65 | 90 | 62 | 90 | 64 | 90 | 68 |

Source: Bureau of State Audits' analysis of data obtained from the Department of Social Services' Child Welfare Services/Case Management System.

### *County CWS Agencies Did Not Always Meet Required Timelines for Completion of Investigations*

State regulations generally require social workers to complete investigations within 30 days of the initial in-person contact. CWS/CMS contains a field for when an investigation is closed.

[17] Appendix B presents the number and disposition of reports of abuse for the three counties we visited.

All three counties closed investigations within 30 days for less than 60 percent of cases we reviewed, based solely on investigation closure dates in the CWS/CMS. However, we found significant lags between when investigations were actually completed and when referrals were reflected as closed in CWS/CMS. Consequently, for the 90 investigations we reviewed, we examined file records to determine when investigations were actually completed. As indicated in the text box, Fresno appeared to have the most difficulty completing investigations on time. However, social workers sometimes held cases open past the 30-day deadline to obtain important additional evidence (for example, physician reports) and to secure needed services for children. We appreciate the balance social workers must strike between avoiding case backlogs and taking the time to make sure that their investigative conclusions are correct and that children are best served.

**Investigations Completed Within 30 Days (30 Reviewed at Each County)**

Alameda: 28 (93 percent)

Fresno: 23 (77 percent)

Sacramento: 26 (87 percent)

Source: Bureau of State Audits' analysis.

### *County CWS Agencies Generally Met Certain Other Referral Requirements*

The screener records all available and appropriate information on each referral and makes a decision on what type of response the referral will receive. State regulations require each referral decision to receive a supervisor's approval. This additional layer of review helps to ensure referrals are responded to appropriately. Referral decisions received supervisory approval at least 90 percent of the time for the 90 referrals we reviewed at the three counties we visited.

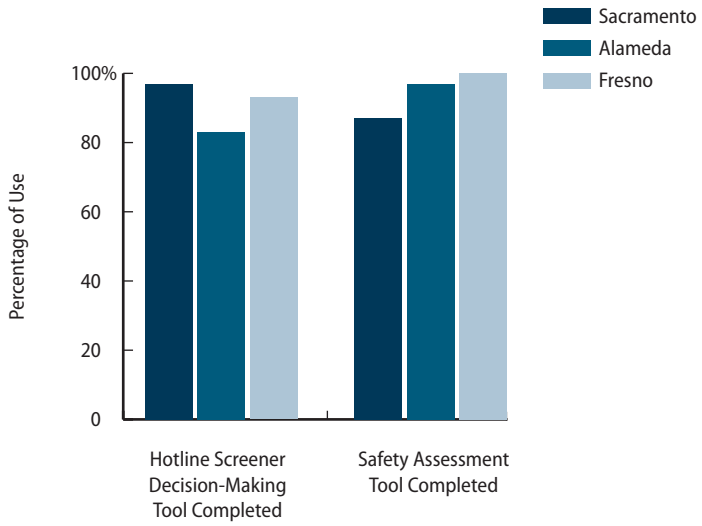
Social Services does not mandate the use of the hotline or safety assessment tools. However, each of the three counties we reviewed has policies directing social workers to use these tools. As shown in Figure 8, the county CWS agencies we visited used these tools for the majority of the files we reviewed.

## Some County CWS Agencies Struggle to Comply With Standards and Best Practices for Ongoing Case Visits

As mentioned earlier, Social Services established a standard of 90 percent for completion of ongoing case visits. Our review of 30 ongoing cases at each of the three counties we visited determined that, on average, Fresno and Sacramento counties are meeting the standard, while Alameda County is not. As indicated in

Figure 9 on the following page, Alameda's compliance ranged from 84 percent to 87 percent. Alameda's interim director stated that it would be focusing on monthly face-to-face contacts to ensure that it is reaching the standard of 90 percent.

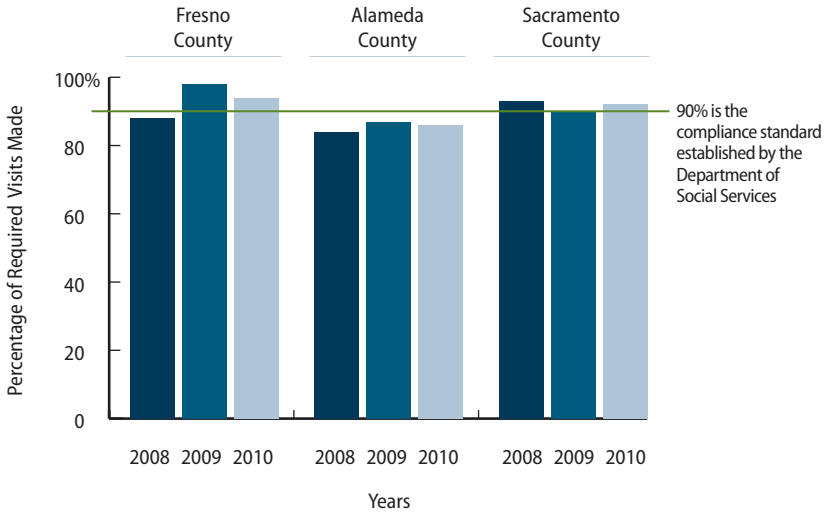
**Figure 8**
**Use of Structured Decision-Making Tools**
**2008 Through 2010**




Source: Bureau of State Audits' analysis of a random selection of 90 referrals at the three counties visited.

Although Sacramento met the established standard, 50 percent of the cases we reviewed had contact exceptions listed. Contact exceptions allow the social worker to visit the child less frequently (for example, once every six months) when certain requirements are met. We asked the acting deputy director of Sacramento's Child Protective Services about its use of contact exceptions. He stated that he also noticed the high number of these when he joined the program in 2008. Consequently, he launched a review to determine the reasons and to improve the county's use and documentation of this practice. However, he asserts that a few weeks after the review began, Sacramento was hit with unprecedented staff reductions, which halted its ability to investigate and correct the use of contact exceptions. He believes that documentation supporting Sacramento's use is lacking in some cases and that the use of some of these exceptions was inappropriate. He told us that Sacramento discontinued its use of contact exceptions in July 2011.

**Figure 9**
**Percentage of Required Ongoing Visits Made**
**Years 2008 Through 2010**




Source: Bureau of State Audits' analysis of a random selection of 90 cases at the three counties visited.

According to Social Services' regulations, the purpose of social worker contact with the child is to achieve several objectives, including verifying the location of the child, monitoring the child's safety, and gathering information to assess the effectiveness of services provided. To best accomplish these objectives, a social worker should regularly visit the child in his or her home. Our review of a random selection of 90 ongoing cases found several instances in which a social worker did not consistently visit children at their residences. Instead, the social worker made monthly contacts at locations such as the county CWS office, a courthouse, the child's school, or another public location. We found at least six cases in both Fresno and Alameda counties where the social worker did not make the monthly visit at the child's residence for three or more consecutive months. In Sacramento, this occurred three times; however, for one of those cases, the social worker made only one of nine monthly visits at the child's residence.

## Social Services Does Not Currently Measure Actual Caseloads at County CWS Agencies

Although a legislatively required workload study published in 2000 recommended particular caseload standards (number of cases or referrals for each worker), the State has never adopted these standards when funding county CWS agencies. Instead, it provides funding based on a combination of older standards and a policy that a county will not be funded below its prior year allocation even if

the number of children in its CWS program decreases (sometimes referred to as the "hold harmless" provision or approach). As discussed in the Introduction, the number of children in the CWS system has decreased from 97,000 to 57,000 (a reduction of over 40 percent) over the last 10 years. The purpose of the state policy to not decrease funding during this time period was to help county agencies lower their caseloads to those suggested by the 2000 workload study. However, because currently no consistent measure and reporting of CWS caseloads exists, the State is limited in its ability to know if the hold harmless provision has been effective and when it should be lifted or revised. Our calculations indicate that some counties may have reduced their caseloads over the last five years and may have already achieved the maximum caseload standards suggested by the workload study.

***Because currently no consistent measure and reporting of CWS caseloads exists, the State is limited in its ability to know if the hold harmless provision has been effective and when it should be lifted or revised.***

The caseload standards traditionally used for budgeting purposes are based on a 1984 agreement between Social Services and the County Welfare Directors Association. In 1998 Senate Bill 2030 (SB 2030) became law and required a study to be completed by an outside contractor evaluating the adequacy of the CWS budgeting methodology. This study was requested due to significant changes in CWS policy and practice, as well as demographic and societal changes that affected the workload demands of the child welfare system since the 1984 standards were agreed to. The SB 2030 team conducted a workload measurement and analysis encompassing all 58 counties and published its report, known as the *SB 2030 Study*, in April 2000. The study recommended two sets of caseload standards: a maximum and an optimal set of standards. Both standards are lower than the caseloads outlined in the 1984 agreement, as seen in Table 6 on the following page.

According to the *SB 2030 Study*, a main goal of caseload maximums is to provide social workers enough time to deliver mandated services to children and their families. If a social worker has too many cases, he or she may have a difficult time performing investigations and case management work within required time frames. In one child death that we reviewed in Sacramento County, the social worker who was assigned to investigate an immediate-response referral from a doctor indicating that a child may have been physically abused by an adult had more than 60 open referrals—much greater than the average of other social workers in Sacramento and more than five times the maximum number recommended by the study. The high caseload, among other potential factors, may have contributed to the social worker not making contact with the family for seven days, not performing a thorough investigation, and not contacting the doctor making the allegation. About a month after the allegation, the mother's boyfriend killed the child. The Sacramento CWS agency indicated that the social worker's actions in this case

did not meet its standards but that it has attempted to address not only this issue but numerous other system breakdowns that occurred in this case.

**Table 6**

**Comparison of 1984 Agreement and Senate Bill 2030 Caseload Standards**

| | 1984 AGREEMENT | SENATE BILL 2030 STUDY | |
|---|---|---|---|
| SERVICE COMPONENT | STANDARD USED FOR BUDGETING PURPOSES | MAXIMUM CASELOAD | OPTIMAL CASELOAD |
| Hotline | 322.50 | 116.10 | 68.70 |
| Emergency response | 15.80 | 13.03 | 9.88 |
| Family maintenance | 34.97 | 14.18 | 10.15 |
| Family reunification | 27.00 | 15.58 | 11.94 |
| Permanent placement | 54.00 | 23.69 | 16.42 |

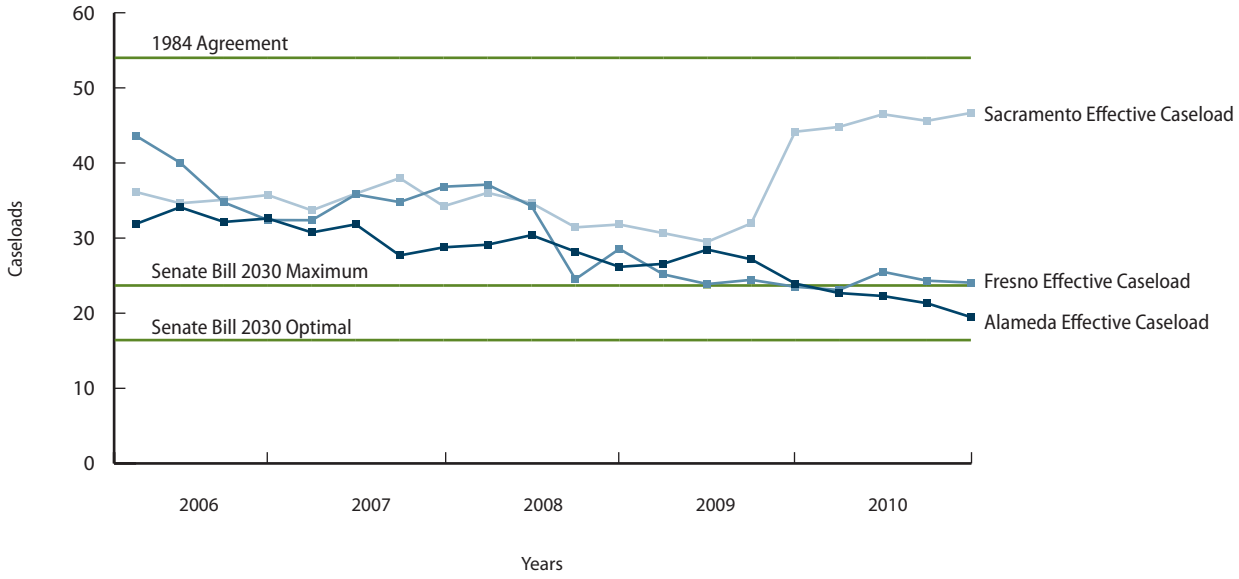
Source: April 2000 study conducted by an outside contractor and published in response to Senate Bill 2030, Statutes of 1998.

For budgeting purposes, Social Services tracks the actual number of cases by the service components shown in Table 6, but the department does not calculate the number of cases per social worker or any caseload averages. Although it does not require counties to track or report caseloads, the three counties we visited do track caseloads for each social worker. However, every county has devised its own calculation methodology and standards against which actual worker caseloads are compared. Some counties' standards are based on agreements with local labor organizations that represent the counties' social workers.

Because Social Services does not calculate caseload averages, we performed these calculations for the three counties we visited.[18] In Figure 10 we present the results of our calculations for the permanent placement component over the past five calendar years. As shown in the figure, Alameda and Fresno counties have recently been able to meet the *SB 2030 Study* maximum caseload standards for the permanent placement service component, while Sacramento County is still struggling with higher caseloads. Appendix A presents county CWS expenditures for the three counties and describes how Sacramento County lost 32 percent of its CWS staff as a result of budget reductions.

[18] Our calculations use data from Social Services' CWS/CMS. As discussed in the Scope and Methodology, the data is of undetermined reliability.

**Figure 10**
**Permanent Placement Caseloads for Three Counties We Visited 2006 Through 2010**



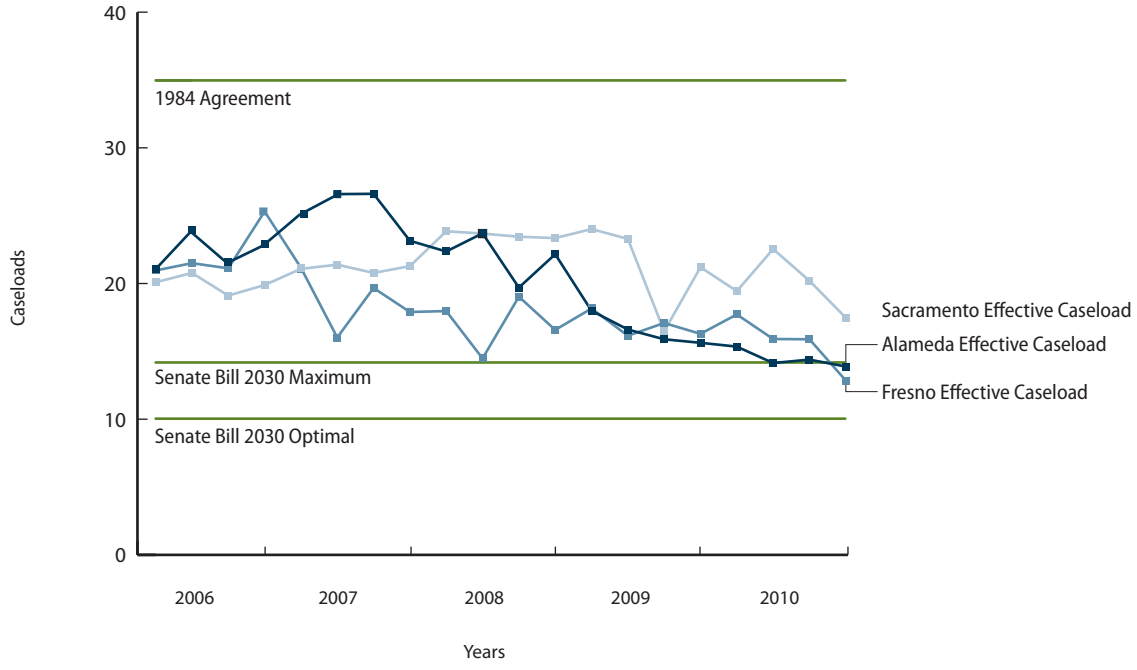

Source: Bureau of State Audits' analysis of data obtained from the Department of Social Services' Child Welfare Services/Case Management System.
Note: The caseloads shown exclude certain county workers, such as clerks, office assistants, and supervisors who do not regularly carry a caseload.

Figure 11 on the following page shows the results of our calculations for the family maintenance component during the same time frame. As with the permanent placement component, Alameda and Fresno counties have also recently been able to meet the *SB 2030 Study* maximum caseload standard for the family maintenance component, while Sacramento County again has higher caseloads. Although Sacramento experienced reductions in family maintenance staffing, its number of family maintenance cases dropped at a faster rate, causing the caseload per worker shown in Figure 11 on the following page to decrease in 2010. As discussed in Appendix A, Sacramento eliminated, as a result of budget reductions, certain voluntary activities.

For the family reunification component, which is not shown in figures 10 or 11, caseloads have decreased in all three counties over the past five years (31 percent in Alameda, 17 percent in Fresno, and 40 percent in Sacramento) with only Fresno still above the

*SB 2030 Study* maximum caseload standard. Our calculations indicate that emergency response caseloads have likewise decreased (37 percent in Alameda, 49 percent in Fresno, and 47 percent in Sacramento), with each county under the *SB 2030 Study* maximum caseload standard. Hotline caseloads—which are actually measured in the number of referrals, not cases—have decreased 39 percent in Alameda and 36 percent in Sacramento but have increased 16 percent in Fresno over the same time period. However, all three counties appear to be well below the *SB 2030 Study* maximum hotline standard. The results of our analysis indicate that some counties may have achieved caseloads within or approaching the *SB 2030 Study* maximum standards and that Social Services needs to develop a method for determining actual caseloads so it can examine the hold harmless provision and possibly halt or revise the policy when appropriate. We believe, based on our own use of CWS/CMS, that the system can be used for this purpose.

**Figure 11**
**Family Maintenance Caseloads for Three Counties We Visited 2006 Through 2010**




Source: Bureau of State Audits' analysis of data obtained from the Department of Social Services' Child Welfare Services/Case Management System.
Note: The caseloads shown exclude certain county workers, such as clerks, office assistants, and supervisors who do not regularly carry a caseload.

## Recommendations

To encourage continued progress and innovation in keeping children safe, Social Services should add to its current CWS performance metrics a measure of the percentage of investigatory visits (both immediate and 10-day) completed on time that excludes attempted investigatory visits from its calculation of successful outcomes.

Social Services should work with the Alameda County CWS agency to improve its percentage of ongoing case visits completed until it at least meets Social Services' compliance goal of 90 percent.

To determine whether the hold harmless provision has been effective in reducing caseloads and whether it should be revised or rescinded, Social Services should refine and use CWS/CMS to calculate and report county CWS caseloads.

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# Chapter 4

## COUNTY CHILD WELFARE SERVICES AGENCIES THAT DO NOT FORMALLY REVIEW CHILD DEATHS MISS OPPORTUNITIES TO LEARN FROM THESE TRAGIC INCIDENTS

### Chapter Summary

County child welfare services (CWS) agencies that do not formally conduct an internal evaluation of the services they delivered to a family prior to a child's death from abuse or neglect are missing opportunities to identify needed changes that may prevent similar future tragedies. Although not required by law, none of the three counties in our review formally evaluated all such deaths that occurred between 2008 and 2010. Alameda County's CWS agency did not formally review any child deaths. Sacramento County's CWS agency only formally reviewed nine of 15 cases of children with CWS history who died from abuse or neglect, and Fresno County's CWS agency formally evaluated four out of five such deaths. Our analysis of their unreviewed child deaths leads us to believe these counties could benefit from evaluating these incidents.

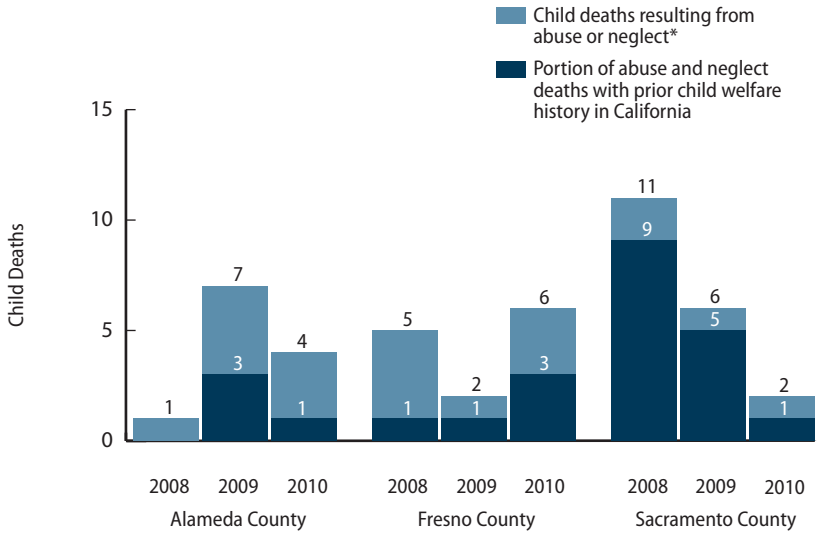
Although not performed in all cases, Fresno and Sacramento counties' death reviews identified several recommendations for improvement. However, neither CWS agency has implemented all of the recommendations stemming from its reviews. Consequently, they may not be realizing the full benefits of their child death reviews.

### Alameda County's CWS Agency Has Not Evaluated Its Relatively Few Child Deaths

Alameda County's CWS agency has not in the past conducted formal internal reviews of children with CWS history who died from abuse or neglect. Our review indicates that the agency could learn from these deaths. As shown in Figure 12 on the following page, we determined from available information that four children with prior CWS history died of abuse or neglect between 2008 and 2010.[19]

[19] Appendix C provides additional information, including demographic details, on child deaths in Alameda, Sacramento, and Fresno counties.

**Figure 12**
**Child Deaths Resulting From Abuse or Neglect**




Sources: Department of Social Services' Child Fatality/Near Fatality information and Child Welfare Services/Case Management System, and Alameda County's child death review team.

* Determinations of whether children died of abuse or neglect were made by county child welfare services agencies.

The interim director of Alameda County's Department of Children and Family Services stated that when a child dies in Alameda County, CWS staff e-mail agency leadership a summary of the child's history with the department and pertinent details regarding the circumstances surrounding the death. The board of supervisors is also notified within 24 hours when the child's death resulted from abuse or neglect. Although the information sent to the board of supervisors provides some information on the child's CWS history, it does not evaluate or analyze the agency's prior actions related to the child and family. She also asserted that internal child death reviews are not required by law. Nonetheless, the interim director—during the course of our audit—stated that the CWS agency could benefit from formally reviewing the small number of child abuse or neglect deaths that had prior CWS history in Alameda County. She stated that the CWS agency will therefore review all such child abuse and neglect deaths that occur subsequent to July 2011.

Our review of the two abuse or neglect deaths of children with CWS history in Alameda County between 2008 and 2010[20] indicates that the CWS agency could learn from reviewing child

[20] Although four children with CWS history died of abuse or neglect between January 1, 2008 and December 31, 2010, only two had CWS history within Alameda County.

deaths. Specifically, in one instance we found that a neighboring county's CWS agency received a referral from law enforcement alleging that a mother, after assaulting another person, endangered her infant while resisting arrest. While investigating the allegation of physical abuse to the infant, the neighboring CWS agency uncovered additional allegations that the mother hit another one of her children, believed that her infant was doing things intentionally, had depression and mental health issues, and that the children's father was physically abusive toward her. During the investigation, the mother and children moved to Alameda County. The neighboring county CWS agency then closed the original referral and passed on the allegations to Alameda County's CWS agency.

However, Alameda County's CWS agency classified these allegations of physical abuse as solely involving emotional abuse, and only requiring contact within 10 days. Eight days after receiving the referral, the social worker met with the mother and her children. During the visit, the social worker observed that the mother had a black eye, but the mother denied domestic violence. The mother admitted that she had anger management problems. After the one visit, the social worker determined that the allegation of emotional abuse was unfounded although the social worker indicated that she had some concerns regarding this case. Less than a week after the social worker made this determination, the mother allegedly killed one of her children.

This example underscores the importance of reviewing such child deaths to determine whether opportunities exist to improve policies and procedures to prevent similar tragedies in the future. If Alameda County's CWS agency had reviewed this child death, resulting agency actions could have included training the social worker(s) who handled this referral on how to properly classify a referral that involves physical abuse and when a referral should be closed or an investigation continued if unresolved concerns exist. If the agency believed this was a systemic issue, it could have taken steps to ensure appropriate training or changes to policies.

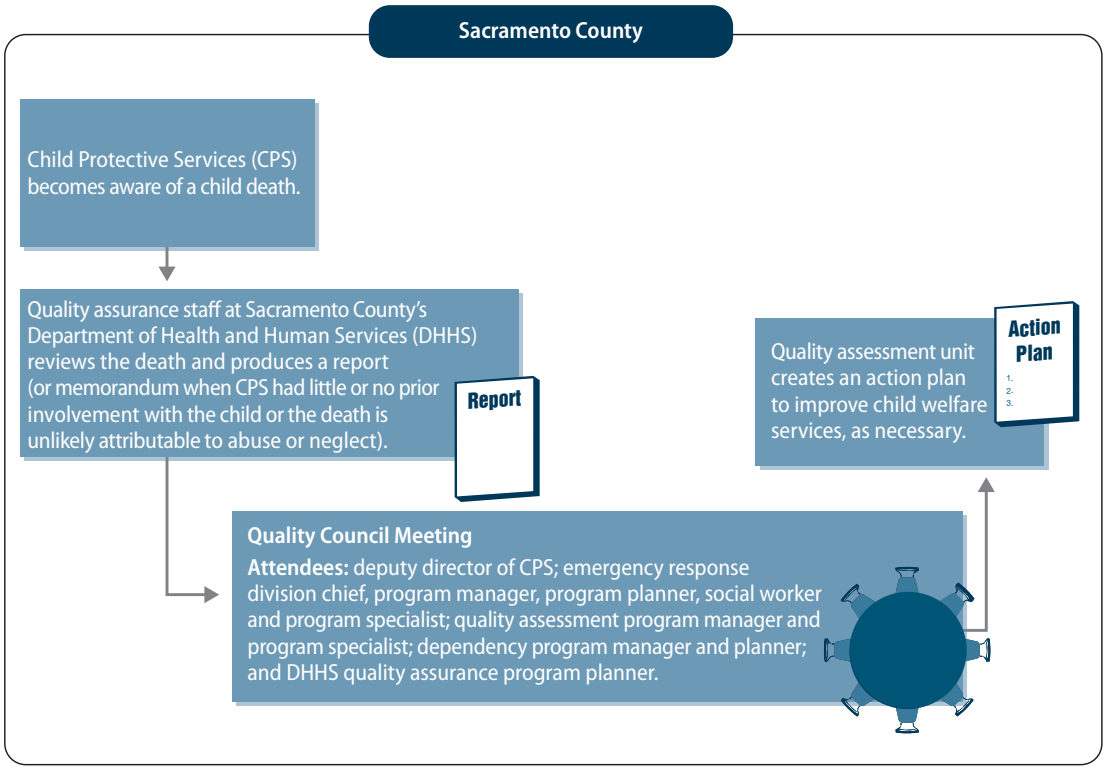
### Sacramento County's CWS Agency Did Not Review All Child Deaths, Nor Did It Implement All Resulting Recommendations

Although Sacramento County's CWS agency reviewed some child deaths, it missed opportunities to identify improvements to its policies and practices by not reviewing all of them. Specifically, it reviewed only nine of the 15 cases of children with prior CWS history who died from abuse or neglect between 2008 and 2010. Additionally, although its review of some child deaths resulted in recommendations for change, Sacramento County could

not demonstrate that it sufficiently implemented all of these recommendations and therefore may not be realizing the full benefits of the reviews it does conduct.

As shown in Figure 13, Sacramento County's process for reviewing child deaths involves an initial report or memorandum produced by quality assurance staff within the county organization overseeing the CWS agency. The process can also include a quality council meeting at which the initial report is discussed and, as needed, a corrective action plan is developed.

**Figure 13**
**Sacramento County Child Welfare Services Agency's Review of Child Deaths**




Source: Personnel from Sacramento County's Department of Health and Human Services.

### *Sacramento County's CWS Agency Reviewed Only a Portion of Child Abuse or Neglect Deaths*

Sacramento County's CWS agency did not formally review six of the 15 cases of children with prior CWS history who died from abuse or neglect within the county between 2008 and 2010. However, according to its quality assurance staff, Sacramento County's Department of Health and Human Services (DHHS)

started reviewing all child deaths that come to the CWS agency's attention in mid-2010. We therefore researched the remaining child deaths and found that Sacramento County missed opportunities to learn important lessons by not reviewing all such deaths.

For example, in one of the incidents the county did not review, a mother allegedly killed one of her children. Although the agency knew she was a suspect (because of what appeared to be a suicide note written by the mother apologizing for what she had done), it allowed the remaining children to stay with a relative, who gave the mother access to her children. Not until 11 days after the first child's death did the CWS agency seek warrants to place the mother's other children in protective custody—an outcome the social worker was originally leaning towards but was instructed by management to attempt to get the mother to voluntarily place the children with a relative if the social worker deemed the relative likely to be an appropriate caregiver. The documentation in the case file leads us to believe the agency should have begun its process for removing the mother's access to the children as soon as it found out that the mother was a suspect, not 11 days later. The agency is authorized to remove a child from a home when the child is unsafe, and we believe it should have done so sooner.

***Although the agency knew a mother was a suspect in the death of one of her children, it allowed her remaining children to stay with a relative, who gave the mother access to her children.***

In another child death case that Sacramento County did not review, the agency received a referral alleging that a child had bruises all over his body, caused by physical abuse of the child by the mother's boyfriend. According to the case file, during the investigation another adult seemed concerned about the allegations. After seeing a bruise on one of the children, the social worker and mother took the child to a doctor. The doctor stated that the bruise could have been caused by the child falling, consistent with the mother's story. During the investigation, the social worker also interviewed the alleged perpetrator once by telephone. The social worker investigating the referral instructed the mother that the boyfriend was not allowed to be alone with the children, although he allegedly sometimes stayed with the mother and lived with his parents, who babysat the children. The referral was not closed—or further investigated—until two weeks later, when the same child was taken to the hospital and shortly thereafter died of allegedly nonaccidental causes. The boyfriend was subsequently arrested in connection with the child's death. If the Sacramento CWS agency had reviewed this child death, it may have identified opportunities to improve its policies or to provide training on when a referral should be investigated further versus when it should be closed.

### *Sacramento County's CWS Agency Could Not Demonstrate That It Has Sufficiently Addressed All of the Recommendations Resulting From the Child Fatalities It Did Review*

*The review conducted by the Sacramento CWS agency subsequent to this incident revealed shortcomings and led to improvements within the agency.*

Through its reviews of child deaths, Sacramento County's CWS agency made some recommendations to strengthen and improve its policies and practices. In some instances, the agency can demonstrate that it implemented these recommendations. For example, in one incident a medical professional alleged that a child had a suspicious injury and that when questioned about it, the family's explanation did not fit the injury. When making in-person contact with the family seven days later, the social worker performed a cursory body check and did not note any marks or bruises that would indicate abuse or neglect. About a month later, the child died of abuse. The review conducted subsequent to this incident revealed shortcomings and led to improvements within the agency. The review stated that the cursory body check did not comply with its policies and procedures. To ensure that sufficient body checks take place in the future, the review recommended that the agency clarify with emergency response supervisors and social workers that "cursory" body checks do not meet acceptable practice standards. To implement this recommendation, the agency made its revised policies and procedures on conducting body checks available to staff on a shared computer network.

The review also noted that the agency received a standard medical report of a suspected child abuse or neglect examination from the reporting medical professional. The report contained additional information on the suspect injury, including its exact location and size. However, this information was unavailable at the time of the investigation because the reporting party mailed the form. To help prevent the recurrence of this issue, the review recommended in December 2008 that intake workers request medical reporting parties to fax rather than mail this form. In August 2011 the agency sent an e-mail to its intake workers instructing them to request that these medical reports on suspected child abuse or neglect be faxed or e-mailed to the intake workers rather than mailed.

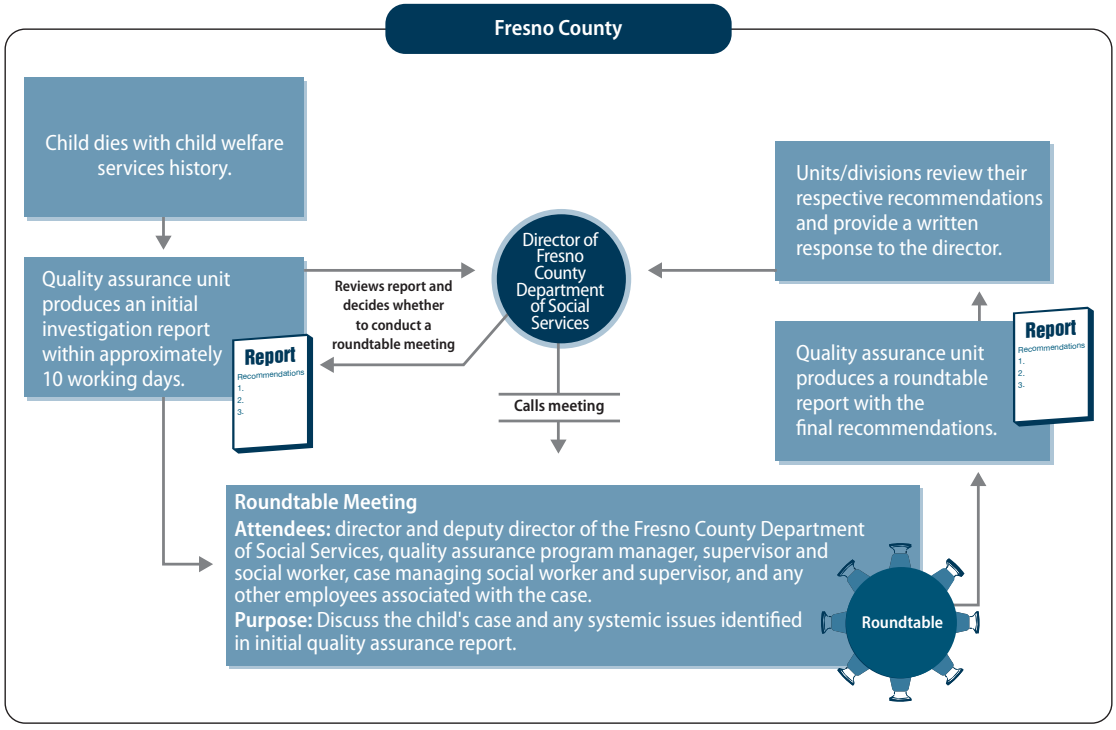
Although Sacramento County's internal child death review process has led to some improvements, it was unable to demonstrate to our office that it sufficiently addressed all of the recommendations that we chose to review. According to the director of Sacramento County's DHHS, the person who created the recommendations prior to mid-2010 did not have enough interaction with or input from child protective services' staff to make final recommendations. Thus, the director believes that some of the recommendations were too general and did not adequately consider existing policies and practices. Consequently, she stated that it was internally understood at the time that such recommendations would not always result in

specific actions. However, she added that the current child death review process, as depicted in Figure 13, was designed to create more meaningful recommendations that will be implemented.

### Fresno County's CWS Agency Evaluates and Learns From Most Child Fatalities but Has Not Implemented All Resulting Recommendations

The child death review process within Fresno County's CWS agency has resulted in recommendations to strengthen and improve the agency. However, Fresno County has not fully implemented some recommendations resulting from its child death reviews. As shown in Figure 14, Fresno County's process for reviewing child deaths includes an initial report, a roundtable meeting, and recommendations. Any units or divisions affected by report recommendations have an opportunity, subsequent to the roundtable meeting, to evaluate and provide a written response to the recommendations.

**Figure 14**
**Fresno County Child Welfare Services Agency's Review of Child Deaths**




Source: Fresno quality assurance program manager.

Fresno County's CWS agency has improved its policies as a result of its child death reviews. For example, in one incident Fresno received a referral from law enforcement reporting that a parent attempted to drop off children at a law enforcement agency because the children were too much to handle. According to Fresno County's internal review, this referral should have resulted in an in-person response by a social worker. But because two prior referrals were still open and law enforcement was not placing a hold on the children, the agency employee receiving the new referral immediately closed it. The employee then sent an e-mail to the social worker investigating the previous referral, notifying her of the new incident. This referral contained new information that would be important for the social worker to assess. The social worker was not at work to respond to this new information. The child was fatally injured the same day the social worker became aware of the e-mail.

According to Fresno's quality assurance program manager, this new information from law enforcement likely should have resulted in a referral that would have required an in-person response by a social worker within 10 days. Consequently, she states that even if a referral had been generated in this case, the social worker would not have seen it prior to the child being fatally injured. Nonetheless, she stated that as a result of the agency's subsequent review of this child death, it developed a new policy regarding families with open referrals so that any new referrals that might have ordinarily been evaluated out are now required to be forwarded to the investigating social worker and the respective supervisor who can more appropriately assess the new information and decide whether to evaluate out the referral or elevate the response priority.

Fresno County reviewed four of the five cases of children with prior CWS history who died from abuse or neglect. Fresno's quality assurance program manager stated that a preliminary review was conducted; however, it did not formally review and provide a written report for one child death because the family had minimal prior CWS history and there were no concerns identified in the preliminary review. Nonetheless, the agency recently amended its policy so that it will now conduct a formal written review of all child deaths that have prior or current CWS involvement.

***Of the 19 recommendations that we reviewed, the agency had not yet fully implemented five.***

Finally, although its child death review process has led to recommendations and improvements, Fresno County's CWS agency has yet to fully implement all the recommendations. Of the 19 recommendations that we reviewed, the agency had not yet fully implemented five. Table 7 shows the five recommendations that Fresno has not fully implemented. To obtain the intended benefits from its reviews, Fresno County should ensure that it implements the reviews' resulting recommendations.

**Table 7**
**Unimplemented Recommendations Resulting From Fresno County Child Welfare Services Agency's Child Death Reviews**

| CHILD WELFARE SERVICES (CWS) AGENCY'S CONCERN WITH INCIDENT | RECOMMENDATION | STATUS |
|---|---|---|
| Social worker did not determine whether police had previously visited the home. | Update policy to require social workers to run a service call history on homes through law enforcement prior to responding to referrals. | Will implement alternative action by January 2012 |
| Mental health, law enforcement, and educational agencies possessed information that could have been helpful to the CWS agency's investigation. | With the assistance of county counsel, develop a joint policy and data sharing system between CWS, educational, law enforcement, and mental health agencies regarding the exchange of information. | Will fully implement within 3-5 years* |
| Foster parent's actions indicated a lack of understanding regarding basic infant care and sudden infant death syndrome (SIDS) prevention. | Provide caregivers training on the prevention of shaken baby syndrome and SIDS. | Will fully implement by January 2012 |
| Social worker could have better assessed the foster parent's ability to meet the child's special needs. | Develop standard questionnaire for social workers calling foster homes to research placement for a minor. | Will fully implement by January 2012 |
| Foster parent documented that one of her least-wanted placement types was drug-exposed infants, yet three drug-exposed infants were placed in her home. | Use information that foster parents provided the agency on standard questionnaires and the licensing case profile sheets when deciding where to place children. | Will fully implement by January 2012 |

Sources: Fresno County Children and Family Services' documents and personnel.

* According to the county's CWS agency, a multidisciplinary group was convened to develop an information and data sharing policy and flagging system. This recommendation is being implemented in phases due to the complexity of confidentiality regulations, resource issues, and data compatibility requirements. The first phase of this project is in its final stages with memorandums of understanding in place between the 34 school districts in Fresno County and a formal policy, and the data system is expected to be launched on January 1, 2012.

## Alternative Means for Evaluating and Learning From Child Deaths Are Insufficient Substitutes for Internal CWS Agency Evaluations

The State and counties have other means—in addition to internal evaluations conducted by some county CWS agencies—to evaluate and learn from child deaths. These reviews by state and other local entities have value but are insufficient substitutes for internal reviews focused on improving CWS agency performance. Table 8 on the following page summarizes the purposes of various state and local entities that review child abuse and neglect deaths.

## Department of Social Services' Information and Reports on Child Abuse and Neglect Deaths Are Dependent on County CWS Agencies

The Department of Social Services' (Social Services) information and reports on child deaths resulting from abuse or neglect are dependent on counties fully and accurately reporting these deaths. Underreporting by county CWS agencies negatively affects Social Services' ability to analyze and annually report statistics on child deaths resulting from abuse or neglect. One of the three county CWS agencies that we reviewed did not report all abuse and neglect

fatalities to Social Services, as required by state law. Since 2008 Alameda County has not reported four fatalities resulting from abuse or neglect. This resulted in Alameda County's CWS agency reporting only eight deaths, instead of the 12 shown in Figure 12 on page 62. The agency did not report these four child fatalities because of an oversight in two cases and because it was unaware of the two remaining child deaths.

**Table 8**
**Entities That Review Child Deaths**

| ENTITY | ACTIVITY |
|---|---|
| **State** | |
| Department of Social Services | Gathers information on child fatalities and near fatalities from county child welfare services (CWS) agencies and any other relevant information in the department's possession and produces an annual report. |
| Department of Public Health, Safe and Active Communities Branch | Maintains a statewide child abuse and neglect fatality tracking system that incorporates information collected by local child death review teams and reconciles that information to information maintained by various state agencies. |
| California State Child Death Review Council (disbanded in 2008 when state funds were cut) | Created to oversee the coordination of state and local efforts to address fatal child abuse and neglect and to create a body of information to prevent child deaths. |
| **Local** | |
| County CWS agencies | As discussed in this chapter, some county CWS agencies perform internal reviews of child deaths to identify opportunities to improve their practices. |
| Child death review teams | Assists local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons and agencies involved in child abuse or neglect cases. |

Sources: Web sites for the departments of Social Services and Public Health, chief of the Department of Public Health's violent injury surveillance unit, county CWS agencies, and California Penal Code, sections 11174.32 through 11174.35.

Our review—comparing fatalities submitted to Social Services with fatalities identified by the county's child death review team—found that the agency was aware of two of the child deaths and investigated those incidents but simply did not report the deaths to Social Services, as required by state law. In contrast, the agency was unaware of, and therefore did not investigate, two other child deaths that resulted from abuse or neglect. According to the interim director of Alameda County's Department of Children and Family Services, law enforcement did not cross report either of these deaths. One death involved an incident in which police believed a mother intentionally killed her child, and the other involved an unidentified deceased child found floating in the bay.

Social Services gathers information on child deaths resulting from abuse and neglect, and then reports on this information in order to comply with state law. In October 2007 the governor approved Senate Bill 39, which requires county CWS agencies to notify Social Services of all child fatalities that occur within their jurisdiction that resulted from abuse or neglect beginning on January 1, 2008.

The bill also requires Social Services to annually report on these fatalities and on any systemic issues or patterns revealed by this information. Social Services' most recent annual report—published in 2011 about child fatalities in 2009—provides high-level statistical information including each child's CWS history, age, gender, and ethnicity. Although the report provides statewide information, we believe it would be more useful if it included child death information by county, information over multiple years, a comparison of counties to one another, and child deaths as a percentage of each county's total child population.

Social Services agrees that its information on child deaths resulting from abuse or neglect is only as good as the information submitted by county CWS agencies. The chief of its children's services operations bureau told us that Social Services does not currently have the staff resources to perform comparisons between the child death information submitted by county CWS agencies and child death information maintained by other parties such as county child death review teams.

### Recommendations

To improve agency practices and increase the safety of children within the CWS system, all county CWS agencies should perform a formal internal review of the services they delivered to each child before he or she died of abuse or neglect and implement any resulting recommendations.

To encourage county CWS agencies to conduct formal internal death reviews, Social Services should revise its annual report on child deaths resulting from abuse or neglect to provide information on whether county CWS agencies conducted such a review of child deaths with prior CWS history. To obtain this information, Social Services should revise its regulations to require all county CWS agencies to not only report child deaths resulting from abuse or neglect but to also require a subsequent report indicating whether an internal child death review was completed.

As part of its instructions related to its outcome review process, Social Services should direct county CWS agencies to include completed internal death reviews in the development of their self-assessments and improvement plans.

As part of its oversight of the outcome review process, Social Services should follow up on whether Fresno and Sacramento counties implemented recommendations resulting from their respective internal death reviews.

To ensure that they report all requisite child deaths to Social Services and investigate all child deaths involving abuse or neglect, county CWS agencies should annually reconcile their child death information with other reliable information on child deaths, such as county child death review team data.

To provide more useful information in its annual report, Social Services should provide child death information broken out by county, not just statewide totals. Further, Social Services should provide more analysis, such as comparing child death information over multiple years and presenting each county's child deaths as a percentage of its total child population.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the scope section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

ELAINE M. HOWLE, CPA
State Auditor

Date: October 27, 2011

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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

# Appendix A

## CHILD WELFARE SERVICES EXPENDITURES FOR THE THREE COUNTIES WE VISITED AND A DISCUSSION OF ANY BUDGET REDUCTIONS

To increase reserves and help reduce the State's deficit, the governor cut $80 million in child welfare services (CWS) money from the State's General Fund for fiscal year 2009–10. This funding reduction was continued in fiscal year 2010–11. This reduction, as well as counties' own economic climates, has likely had an effect on some counties' ability to provide child welfare services. However, as discussed below, only one of the three counties we visited has been severely affected by budget reductions.

The expenditures listed in the tables on the following pages are the amounts paid from the county expense claim system (expense claims) operated by the Department of Social Services (Social Services) for program codes designated by Social Services as child welfare services. These costs include amounts paid in support of the counties' administration of the various components of child welfare services (as described in the Introduction). Expense claims are reviewed and certified by each county's auditor.

### Alameda County

According to Alameda County, it has been able to weather the current economic situation better than other counties due to its participation in a federal demonstration project designed to test how a flexible CWS funding structure might improve the safety, permanency, and well-being of children. Alameda and Los Angeles counties are the only two participating in this project, which started on July 1, 2007, and is slated to end on June 30, 2013. Under the project, Alameda County receives a set funding allocation for administrative costs and out-of-home placement costs regardless of whether the number of children in its CWS program increases or decreases. It is allowed to carry certain unspent funds over to future years for reinvestment in its CWS program. At the end of fiscal year 2009–10, for example, Alameda County had a cumulative reinvestment carryover amount of $8.5 million. With its reinvestment funds, the funding flexibility under the project has, according to Alameda County, allowed it to hire additional social workers as well as reinvest in projects that will improve outcomes. As indicated by Table A.1 on the following page, Alameda County's spending on CWS has increased despite the State's difficult fiscal climate.

**Table A.1**
**Alameda County Child Welfare Services Expenditures**
**(In Millions)**

| FISCAL YEAR | CASEWORKER COSTS* | SUPPORT STAFF COSTS (ADMINISTRATIVE AND CLERICAL)† | SUPPORT OPERATING COSTS‡ | DIRECT COSTS§ | OTHER‖ | TOTALS |
|---|---|---|---|---|---|---|
| 2005–06 | $26.4 | $10.5 | $10.3 | $3.3 | $3.5 | **$54.0** |
| 2006–07 | 26.8 | 11.5 | 9.4 | 3.7 | 4.0 | **55.4** |
| 2007–08 | 29.1 | 12.8 | 9.7 | 7.8 | 9.3 | **68.7** |
| 2008–09 | 32.8 | 14.8 | 10.9 | 9.4 | 7.5 | **75.4** |
| 2009–10 | 34.6 | 15.4 | 10.6 | 11.3 | 10.3 | **82.2** |

**CHILD WELFARE SERVICES EXPENDITURES BY FUNDING SOURCE FOR TWO FISCAL YEARS**

**FISCAL YEAR 2008–09**

| | |
|---|---|
| Federal | $44.9 |
| State | 21.0 |
| County | 9.5 |
| **Total** | **$75.4** |

**FISCAL YEAR 2009–10**

| | |
|---|---|
| Federal | $47.6 |
| State | 24.1 |
| County | 10.5 |
| **Total** | **$82.2** |

Sources: Alameda County's expenditure records from its County Expense Claims for the fiscal years noted.

Notes: The amounts shown in the table are the allocated and direct county costs attributable to the Child Welfare Services (CWS) program. When seeking reimbursement from the State, the county completes an online County Expense Claim maintained by the Department of Social Services (Social Services). The county's administrator and auditor certify the accuracy of their claims and we verified that these totals agreed with the amounts in the claims.

The administration costs in the table do not include direct payments made primarily to out-of-home care providers (e.g. foster family agencies, foster family homes, group homes), which ranged from a high of $69 million in fiscal year 2005–06 to a low of $54 million in fiscal year 2009–10. These amounts do not include payments for placements in which there is no federal or state participation in costs.

According to Social Services' County Expense Claims manual, the above columns have the following meanings according to the footnotes:

* Caseworker costs are the salaries and benefits of caseworkers and their first-line supervisors.

† Support staff are non-caseworker personnel and consist of general administration staff, program administration staff, and clerical staff.

‡ Support operating costs include expenditures for travel, space, telephones, supplies, etc.

§ Direct costs are those that benefit only one CWS program and are not included in the cost-allocation process. Such costs might include program start-up and one-time only costs that cannot be equitably distributed via a cost-allocation process.

‖ The amounts shown under "Other" are for the county's information technology costs and staff development costs.

## Fresno County

According to the deputy director of Fresno's CWS agency (deputy director), the agency has been challenged for several years, which has required the county to look for other sources to support its work. The deputy director stated that funding from the State is based on a reimbursement rate (approximately $81,000) that is well below the rate many other counties receive.[21] According to the deputy director, although this funding disparity has been a constraint on Fresno, it has been as creative as possible to make sure children are protected. For example, the agency indicated it has sought partnerships with numerous foundations that have assisted the agency in analyzing various issues and promoting various change efforts. Fresno also stated that grants from private foundations are used to augment the county's funding. A business

[21] By way of comparison, the estimated reimbursement rate used for nearby Kern County's budget is $101,000.

manager in Fresno County's Department of Social Services stated that the county has been careful to use funding from programs other than CWS programs when possible to preserve resources for children only eligible for CWS funding. As indicated by Table A.2, Fresno County has maintained a fairly stable expenditure level for child welfare services despite funding limitations and despite not being part of the federal demonstration project described earlier.

**Table A.2**
**Fresno County Child Welfare Services Expenditures**
**(In Millions)**

| FISCAL YEAR | CASEWORKER COSTS | SUPPORT STAFF COSTS (ADMINISTRATIVE AND CLERICAL) | SUPPORT OPERATING COSTS | DIRECT COSTS | OTHER | TOTALS |
|---|---|---|---|---|---|---|
| 2005–06 | $20.8 | $5.4 | $5.5 | $5.5 | $2.0 | **$39.2** |
| 2006–07 | 21.2 | 5.8 | 5.0 | 7.4 | 1.8 | **41.2** |
| 2007–08 | 22.7 | 6.2 | 3.9 | 6.3 | 2.6 | **41.7** |
| 2008–09 | 23.7 | 7.1 | 4.4 | 6.1 | 2.3 | **43.6** |
| 2009–10 | 24.7 | 7.2 | 6.9 | 5.9 | 1.8 | **46.5** |

CHILD WELFARE SERVICES EXPENDITURES BY FUNDING SOURCE FOR TWO FISCAL YEARS

| FISCAL YEAR 2008–09 | |
|---|---|
| Federal | $27.3 |
| State | 10.7 |
| County | 5.6 |
| **Total** | **$43.6** |

| FISCAL YEAR 2009–10 | |
|---|---|
| Federal | $25.0 |
| State | 10.3 |
| County | 11.2 |
| **Total** | **$46.5** |

Sources: Fresno County's expenditure records from its County Expense Claims for the fiscal years noted.

Notes: All footnote explanations are included in Table A.1 and are not repeated in this table.

The administration costs in the table do not include direct payments made primarily to out-of-home care providers (e.g. foster family agencies, foster family homes, group homes), which decreased from $50 million in fiscal year 2005–06 to $47 million in fiscal year 2009–10. These amounts do not include payments for placements in which there is no federal or state participation in costs.

## Sacramento County

Sacramento County has been severely affected by budget cuts. According to Sacramento County CWS officials, Sacramento County child welfare services experienced a significant funding cut in fiscal year 2009–10. The agency lost 32 percent of its staff positions. Agency officials indicated that a reorganization was initiated in February 2010 to make more efficient use of the county's resources, which included combining the family maintenance, family reunification, and permanent placement service components so that a caseworker can carry a case across the different service components instead of handing it off to another specialist. Agency officials also indicated that in 2009 Sacramento County eliminated a program that provided voluntary child welfare services to families whose children were at risk of abuse or neglect. According to agency officials, the hotline unit refocused its referral assessments to align with the strict legal definition of child abuse and neglect. The officials stated that previously the agency might have opened a case that fell under the umbrella of preventive care, but those

cases are now either referred to a community-based program or evaluated out (closed). The results of these budget cuts appear in the significant reduction in fiscal year 2009–10 expenditures shown in Table A.3.

**Table A.3**
**Sacramento County Child Welfare Services Expenditures**
**(In Millions)**

| FISCAL YEAR | CASEWORKER COSTS | SUPPORT STAFF COSTS (ADMINISTRATIVE AND CLERICAL) | SUPPORT OPERATING COSTS | DIRECT COSTS | OTHER | TOTALS |
|---|---|---|---|---|---|---|
| 2005–06 | $45.2 | $13.4 | $23.8 | $7.5 | $1.0 | **$90.9** |
| 2006–07 | 49.2 | 16.0 | 21.9 | 7.9 | 4.0 | **99.0** |
| 2007–08 | 50.4 | 17.0 | 22.7 | 9.1 | 6.6 | **105.8** |
| 2008–09 | 55.4 | 18.2 | 24.6 | 8.1 | 4.5 | **110.8** |
| 2009–10 | 46.7 | 15.2 | 19.9 | 4.5 | 3.4 | **89.7** |

CHILD WELFARE SERVICES EXPENDITURES BY FUNDING SOURCE FOR TWO FISCAL YEARS

FISCAL YEAR 2008–09

| | |
|---|---|
| Federal | $55.1 |
| State | 29.3 |
| County | 26.4 |
| **Total** | **$110.8** |

FISCAL YEAR 2009–10

| | |
|---|---|
| Federal | $48.3 |
| State | 28.2 |
| County | 13.2 |
| **Total** | **$89.7** |

Sources: Sacramento County's expenditure records from its County Expense Claims for the fiscal years noted.

Notes: All footnote explanations are included in Table A.1 and are not repeated in this table.

The administration costs in the table do not include direct payments made primarily to out-of-home care providers (e.g. foster family agencies, foster family homes, group homes), which ranged from a high of $108 million in fiscal year 2005–06 to a low of $88 million in fiscal year 2009–10. These amounts do not include payments for placements in which there is no federal or state participation in costs.

# Appendix B

## INFORMATION ON REPORTS OF ABUSE AND NEGLECT

The Joint Legislative Audit Committee directed the Bureau of State Audits to provide, for the last five years and for the counties we visited, the number of reports of abuse and neglect (referrals) and the disposition of these reports. Table B presents the information for Alameda, Fresno, and Sacramento counties.

**Table B**
**Total Number of Referrals and Disposition of Referrals for the Three Counties We Visited**

| COUNTY | YEAR ALLEGATION RECEIVED | NUMBER OF REFERRALS | NUMBER OF ALLEGATIONS* | SUBSTANTIATED ALLEGATIONS | INCONCLUSIVE ALLEGATIONS | UNFOUNDED ALLEGATIONS | ALLEGATIONS EVALUATED OUT | ALLEGATIONS WITH NO DISPOSITION OR ENTERED IN ERROR |
|---|---|---|---|---|---|---|---|---|
| Alameda | 2006 | 11,789 | 21,596 | 2,387 | 2,554 | 6,304 | 10,312 | 39 |
| | 2007 | 10,405 | 18,772 | 2,123 | 1,376 | 5,789 | 9,462 | 22 |
| | 2008 | 10,260 | 19,016 | 2,134 | 1,111 | 5,991 | 9,743 | 37 |
| | 2009 | 9,315 | 17,348 | 1,702 | 931 | 6,043 | 8,636 | 36 |
| | 2010 | 9,226 | 16,242 | 1,180 | 893 | 6,168 | 7,879 | 122 |
| **Totals** | | **50,995** | **92,974** | **9,526** | **6,865** | **30,295** | **46,032** | **256** |
| Fresno | 2006 | 11,271 | 26,767 | 3,219 | 3,957 | 13,353 | 6,237 | 1 |
| | 2007 | 12,437 | 32,105 | 3,513 | 5,865 | 15,126 | 7,599 | 2 |
| | 2008 | 12,028 | 31,489 | 2,802 | 3,482 | 15,545 | 9,660 | 0 |
| | 2009 | 13,593 | 36,807 | 3,312 | 3,736 | 18,897 | 10,860 | 2 |
| | 2010 | 13,571 | 37,322 | 3,288 | 3,810 | 18,576 | 11,419 | 229 |
| **Totals** | | **62,900** | **164,490** | **16,134** | **20,850** | **81,497** | **45,775** | **234** |
| Sacramento | 2006 | 18,487 | 37,435 | 7,206 | 11,675 | 11,342 | 6,615 | 597 |
| | 2007 | 19,038 | 38,190 | 7,168 | 11,566 | 11,008 | 7,104 | 1,344 |
| | 2008 | 19,232 | 39,658 | 7,675 | 13,091 | 10,529 | 7,008 | 1,355 |
| | 2009 | 17,304 | 34,737 | 5,365 | 11,831 | 8,796 | 8,102 | 643 |
| | 2010 | 16,002 | 30,767 | 3,555 | 8,489 | 8,720 | 8,729 | 1,274 |
| **Totals** | | **90,063** | **180,787** | **30,969** | **56,652** | **50,395** | **37,558** | **5,213** |

Source: Bureau of State Audits' analysis of data obtained from the Department of Social Services' Child Welfare Services/Case Management System.

* A single referral may consist of several allegations; thus, the number of allegations exceeds the number of referrals.

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# Appendix C

## INFORMATION ON CHILDREN WITH PRIOR CHILD WELFARE HISTORY THAT DIED OF ABUSE OR NEGLECT

The Joint Legislative Audit Committee directed the Bureau of State Audits to provide specific information on children who died of abuse or neglect and had prior child welfare services history. Table C presents the information for these children in Alameda, Fresno, and Sacramento counties.

**Table C**
**Information on Child Deaths Resulting From Abuse or Neglect, and With Child Welfare Services History Years 2008 Through 2010**

| | | COUNTY | | | |
|---|---|---|---|---|---|
| | | ALAMEDA | FRESNO | SACRAMENTO | TOTALS |
| **Child Welfare Services (CWS) History Information** | | | | | |
| Prior CWS referrals* | On child or sibling† | 4 | 5 | 15 | **24** |
| | On child or sibling within 2 years prior to death | 3 | 5 | 12 | **20** |
| | Open referral or case on child or sibling at time of fatal incident | 1 | 2 | 5 | **8** |
| **Child Death Information** | | | | | |
| Cause of death | Blunt force trauma or shaken baby syndrome | 0 | 5 | 8 | **13** |
| | Suffocation or drowning | 2 | 0 | 4 | **6** |
| | Other | 2 | 0 | 3 | **5** |
| Alleged perpetrator‡ | Father | 0 | 1 | 6 | **7** |
| | Mother | 2 | 3 | 7 | **12** |
| | Mother's significant other | 2 | 3 | 5 | **10** |
| | Foster parent | 0 | 1§ | 0 | **1** |
| | Other | 0 | 1 | 0 | **1** |
| **Demographic Information** | | | | | |
| Gender | Male | 3 | 2 | 8 | **13** |
| | Female | 1 | 3 | 7 | **11** |
| Age | <1 | 1 | 2 | 4 | **7** |
| | 1-2 | 1 | 0 | 4 | **5** |
| | 3-5 | 2 | 2 | 7 | **11** |
| | 6-12 | 0 | 1 | 0 | **1** |
| Ethnicity | White | 1 | 2 | 1 | **4** |
| | Hispanic | 1 | 2 | 4 | **7** |
| | Asian | 0 | 0 | 4 | **4** |
| | African American | 2 | 1 | 5 | **8** |
| | Other | 0 | 0 | 1 | **1** |

Source: Child Welfare Services/Case Management System.

* Referrals are reports of suspected child abuse or neglect. County CWS agencies decide whether to investigate the referral.

† In one instance, we include a child death in which a grandparent had prior CWS history as an alleged perpetrator because the child and mother lived with the grandparent.

‡ The total number of alleged perpetrators is greater than the number of child deaths because some fatalities involved multiple individuals.

§ Only one child died while placed in foster care, and the county and the Department of Social Services received no prior complaints on this foster parent prior to the death.

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*(Agency comments provided as text only.)*

Department of Social Services
744 P Street
Sacramento, CA 95814

October 7, 2011

Ms. Elaine Howle, State Auditor*
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for your review and recommendations to improve the oversight of California's efforts to keep children and adults safe. The *Child Welfare Services: California Can and Must Provide Better Protection and Support for Abused and Neglected Children* (Audit 2011-101.1) audit report takes a constructive look at the functions and county oversight responsibilities of the California Department of Social Services (CDSS). Additionally, the report includes a more in-depth description of several counties and how the CDSS and counties work together.

The CDSS views the recommendations in this audit through the forward-looking lens of the changing roles and functions brought about by the realignment of child welfare services in California, as recently enacted by the Legislature and the Governor. The CDSS remains the single state agency responsible for overseeing federal funding for child welfare, adoption and foster care, and thus for compliance with federal funding and statutory requirements. At the same time, realignment provides counties with increased flexibility to implement programs and services that meet their local community needs. The CDSS and the counties have a shared responsibility and commitment to achieving positive outcomes for children and families, and thus some of the recommendations in the audit report will be addressed directly by CDSS or in collaboration with our county partners.

The State and counties protect and serve vulnerable children and adults through the licensure of care facilities, efforts to preserve and maintain families, and careful placement of children who are in the foster care system. We are pleased to see that this audit report recognizes the State-county relationship and the importance of data collection and analysis to support and inform our work with children and families, and we concur with the audit report's them that preventive efforts are effective.

The CDSS generally agrees with the findings and recommendations of the report. Our comments on specific items are enclosed. We appreciate the collaborative manner in which your staff conducted the work leading to this report, and look forward to an ongoing analysis of appropriate responses to identified issues. If you have additional questions, I can be reached at (916) 657-2598.

Sincerely,

*(Signed by: Pete Cervinka for)*

WILL LIGHTBOURNE
Director

Enclosure

* California State Auditor's comments begin on page 89.

California Department of Social Services (CDSS)
Responses to Recommendations in the Child Protective Services Oversight Audit - 2011-101.1

Chapter 1

1.1 *To ensure that vulnerable individuals, including foster children, are safe from sex offenders, Social Services should complete follow-up on the remaining address matches our office provided in July 2011 and take appropriate action, as well as relaying information to Justice or local law enforcement for any sex offenders not in compliance with registration laws.*

CDSS agrees with this recommendation and is completing investigation of all addresses provided by the Bureau of State Audits (BSA). As of October 6, 2011, the Department and counties have completed 99 percent of the investigations indicated by these addresses. CDSS also has notified local law enforcement in those situations where a sex offender was identified as being out of compliance with registration laws, and reporting of erroneous data identified through the investigations to the Department of Justice (DOJ) will occur soon.

1.2 *Social Services should begin to conduct regular address comparisons using Justice's sex offender databases. If Social Services believes it needs additional resources to do so, it should justify and seek the appropriate level of funding. If efforts to obtain additional resources fail, Social Services should assign this high-priority task to existing staff.*

CDSS agrees that address comparison provides an additional protection for vulnerable clients in care, and agrees that prevention should be part of the protection as noted by the BSA later in the report. There are many key partners within the community of individuals and agencies responsible for the prevention and detection of danger to clients in care, including CDSS and the counties.

We are concerned, however, that performing matches against every known sex offender address may not be the most effective means of prevention and ensuring protection. The process involved in this audit required CDSS and counties to investigate every known address of sex offenders, including addresses that were years and in some cases, decades, out of date. The California Sex and Arson Registry (CSAR) includes effective dates of address and identifies active and inactive addresses, and future processes to compare addresses therefore should focus on information technology solutions to minimize the need for staff to manually search through and verify information. The CDSS is exploring solutions that leverage technology and key partners to create an efficient and effective process to provide this additional protection.

The CDSS and its partners have not waited for an information technology solution, however. The CDSS this year began using an evidence-based "key indicator" inspection tool that enables faster but still-accurate in-person inspections and thus enables more of them to occur. Additionally, a number of related preventative measures already have been implemented:

- Developed and implemented procedures to check all new licensing applications against the Megan's Law Website, and to check existing facility addresses against the Megan's Law Website prior to an inspection.

- Installed additional California Law Enforcement Telecommunication System (CLETS) devices around the state to facilitate investigations.

- Reminded child care licensees about statutory requirements to include references to the Megan's Law Website and poster, on both the Child Care Center Notification of Parent's Rights, and the Family Child Care Home Notification of Parent's Rights form and poster.

- Developed and implemented the MyCCL Website to send timely alerts to licensees, and published information about the Megan's Law Website in the CDSS quarterly licensing newsletters.

- Issued a letter to all licensees reminding them of their shared responsibility to ensure the safety of the clients they serve and to be more aware of their surroundings and periodically check the Megan's Law Website.

1.3 *To help keep children safe, the Legislature should consider enacting the following:*

- *A general prohibition of registered sex offenders living or working in licensed children's facilities or Child Welfare Services (CWS) placement.*

- *A requirement that all law enforcement staff overseeing sex offenders make sure that the addresses sex offenders submit for registration do not match a licensed facility for children or a foster home.*

- *A requirement that Social Services make available to law enforcement in an efficient manner the addresses of its children's facilities and foster homes.*

CDSS agrees with this recommendation, but notes that laws already exist that prohibit registered sex offenders from working or residing in licensed children's facilities or CWS placements. Existing laws further require anyone having routine contact with a child in care to be fingerprint cleared. These statutes also specify crimes, including crimes requiring registration as a sex offender that permanently ban an individual from a facility or contact situation. In addition, licensees are accountable by jeopardizing their licenses or through civil fines for allowing an unauthorized individual to work or reside in a children's care arrangement. (1)

Law enforcement staff overseeing sex offenders is a vital partner in ensuring sex offenders are not registered at addresses that create a health and safety risk. As part of the 2009-10 Governor's Budget, the prior Administration proposed to fund the development of a secure website that could be accessed by local law enforcement and parole agents to make sure the registered sex offender would not be residing or working at a licensed site. This proposal was not adopted, but the proposal would have helped prevent the presence of a registered sex offender in a licensed setting or at a CWS placement site. Recognizing this, and in the absence of funding, the CDSS and its partners took the actions described above in our response to Item 1.2.

1.4 *To provide sufficient oversight of county CWS agencies with delegations to licensing foster homes, Social Services should complete at least once every three years comprehensive reviews of these agencies licensing activities.*

CDSS agrees with this recommendation, as it is consistent with our existing internal standard. Beginning in the current fiscal year, our performance on this measure has improved, and we soon expect to meet this important internal triennial standard.

1.5 *To ensure that its licensees, including state-licensed foster homes, foster family agencies, and group homes, are in compliance with applicable requirements and that children are protected, Social Services should complete on-site reviews at least once every five years as required.*

CDSS agrees with this recommendation, and has historically substantially met the minimum statutory five year visit frequency standard. Further, the CDSS has implemented a more frequent regime of visits than the five year requirement despite significant declines in filled analyst positions over the past several years. As noted above, a new evidence-based "key indicators" inspection tool has been implemented and is being further refined this year based upon its usage experience under Community Care Licensing's (CCL) "New Directions" efforts. The outcome of this effort also will better focus subsequent facility reviews on those posing the greatest risk to client health and safety.

1.6 *To encourage more effective communication from county CWS agencies regarding its licensees, Social Services should specify in regulations what types of situations or allegations the agencies should forward to its enforcement units.*

(2) CDSS disagrees with this recommendation, only because the situations that require notice to CCL, counties, and other partners already are spelled out. For example, a child death, injury or harm to a client, the need to seek medical attention, a client/resident left unsupervised resulting in the client wandering away, and client abuse or sexual molestation all currently require notification. In addition, as mandated reporters, CDSS and partner agencies cross-report these incidents.

Further, CDSS attorneys work with CCL and also on behalf of county licensing departments to initiate legal actions if necessary to revoke a license, terminate approval for a foster parent, prohibiting the presence of an individual that may cause harm to a client in care, and so forth. In these cases, the action is shared so that sister agencies can be aware of these actions when and if a person attempts to work or be licensed in another setting.

(2) The CDSS will provide additional guidance to counties to ensure consistent awareness regarding existing requirements.

1.7 *To ensure that county CWS agencies send required reports of abuse and neglect to Justice, Social Services should remind county CWS agencies of applicable requirements and examine the feasibility of using CWS/CMS to track compliance with these statutory provisions.*

CDSS concurs with this recommendation, and will draft an All County Information Notice (ACIN) reminding counties of the conditions that warrant a cross-report to appropriate law enforcement agencies. Further, CDSS will utilize the existing CWS/CMS system governance process to explore the feasibility of automatically documenting reports to law enforcement of abuse and neglect.

Chapter 2

2.1 *To ensure that rates paid to private foster family agencies (FFAs) are appropriate, Social Services should analyze the rates and provide reasonable support for each component of the rate, especially the 40 percent administrative fee it currently pays private agencies.*

Please see the response to the following item.

2.2 *Social Services should create and monitor compliance with clear requirements specifying that children placed with these agencies must have elevated treatment needs that would require a group home placement if not for the existence of these agencies' programs.*

CDSS will examine both of the above recommendations in the context of existing work on congregate care reform. Congregate care reform seeks not only to reform the existing system of group home care but to ensure that a continuum of placement options exist to meet the broad range of treatment needs presented by children in foster care. This includes developing alternatives to group homes such as Intensive Treatment Foster Care and Multidimensional Treatment Foster Care. Past experience has demonstrated that making changes in one placement type and its associated fiscal incentives, without considering the continuum of placement options, can have detrimental overall consequences. As foster family agencies are one placement option for children, their appropriate role will be considered in the context of this reform effort. (3)

2.3 *At a minimum, Social Services should revise its regulations so licensed foster homes have a higher priority than foster family agencies for children that do not have identified treatment needs.*

CDSS generally agrees on a policy basis that licensed foster homes are the preferred placement type for children that do not have identified treatment needs. However, this recommendation will be considered within the context of the discussion immediately above about the continuum of placement options, and also in the context of recently enacted program realignment. (4)

2.4 *Require county CWS agencies to file in the Child Welfare Services Case Management System a detailed justification for any child placed with a foster family agency or group home.*

The CDSS believes that explanations of placement decisions are routinely provided by county agency staff pursuant to current statute and regulations, as well as the requirements of local dependency courts. However, no specific instructions currently exist that provide counties with a particular format or standard location for such explanatory language within the CWS/CMS system. Consequently, placement justifications can be found in court narratives, paper case files, various text fields, and other places within the CWS/CMS system. The CDSS will work with counties through the CWS/CMS governance structure to explore the feasibility of developing a standard system format and/or location for placement decision justification statements. (5)

2.5 *Create a mechanism by which it can efficiently check for compliance with the needs-justification requirement.*

This recommendation will be considered in the context of the response to Item 2.4, above. (5)

2.6 *To achieve greater cooperation from county CWS agencies and make it possible for some county CWS agencies to improve their placement practices, CDSS should consider seeking legislation to create a funding alternative that allow these agencies to retain a portion of the state funds they save as a result of reducing their reliance on private FFAs. The agencies would use these funds to support placement activities necessary to achieve the savings.*

Effective beginning with state fiscal year 2011-12, there no longer is a state General Fund share of costs for the provision of child welfare services, which includes the costs for placement of children in foster family homes and foster family agencies. Instead, a county realignment fund has been established using certain tax revenues, which are directly deposited by the State Controller into various local government accounts. The amount of state funds placed in these accounts is legislatively established and based on historic funding patterns.

Because there are financial incentives for a county to place a child in the most cost-efficient placement type that will meet his or her needs, CDSS believes that it is prudent to postpone consideration of any alternative

funding incentives until data relating to county placement dynamics in light of those incentives is available and evaluated. These incentives also will be considered as part of the congregate care reform effort described earlier.

Chapter 3

3.1 *Work with Alameda County CWS agency to improve its percentage of ongoing cases visit completed until it at least meets CDSS compliance goal of 90 percent.*

The CDSS concurs with this recommendation, and will monitor these data quarterly and confer with the county to determine where areas of improvement are needed and the level progress made toward achieving the compliance goal.

3.2 *Add to its current CWS performance metrics a measure of the percentage of investigatory visits- both immediate and 10 day- completed on time (attempted investigatory visits should be excluded from the calculation of successful outcomes).*

(6) The CDSS agrees that there is value in measuring timely conduct of investigatory visits. However, we disagree that the exclusion of attempted visits would result in a valid indicator of county performance. While a measure could be developed, it likely would be of limited utility given the myriad of legitimate reasons (no one home during the visit, address that is incorrect, etc.) that attempted visits do not result in actual face-to-face contacts. The CDSS will work with counties through the CWS/CMS governance structure to explore the feasibility of developing a timely conduct performance metric.

3.3 *To determine whether the hold harmless provision has been effective in reducing caseloads and whether it should be revised or rescinded, CDSS should refine and use its CWS/CMS database to calculate and report county CWS caseloads.*

(7) While CDSS agrees that CWS/CMS could and should be used to calculate and report county caseloads, the Department does not agree with this finding, as the state's hold harmless policy does not influence overall caseload for the CWS program. It is a fiscal policy related to county administrative costs. Due to budget constraints, the state has not funded county cost increases since fiscal year 2001-02. This policy was instituted to avoid creating a disincentive for counties that create innovative programs or have other factors that result in decreases in out of home care for children.

Chapter 4

4.1 *To improve agency practices and increase the safety of children within the CWS system, all county CWS agencies should perform a formal review of the services they delivered to each child before he or she died of abuse or neglect and implement any resulting recommendations.*

The CDSS agrees that county CWS agencies should perform an internal review of fatalities related to abuse and neglect, in addition to the regular work of child death review teams.

4.2 *To encourage county CWS agencies to conduct formal internal death reviews, the CDSS should revise its annual report on child deaths resulting from abuse or neglect to provide information on whether county CWS agencies conducted a formal review of child deaths with prior CWS history.*

The CDSS agrees that county CWS agencies should perform an internal review of fatalities related to abuse and neglect. However, we do not believe that the annual report mandated by Senate Bill (SB) 39 is an appropriate vehicle for encouraging such practice among county CWS agencies. Rather, the CDSS believes that additional guidance to counties in this area via an All County Letter (ACL) or ACIN would be a better vehicle for facilitating and encouraging such county practice. Therefore, the CDSS will issue such instructions to county CWS agencies to conduct internal reviews and utilize the information gained from such reviews to inform their county assessments and system improvement plans as a best practice. (8)

4.3 *To obtain this information CDSS should revise its regulations to require all county CWS agencies to not only report child deaths resulting from abuse or neglect but to also require a subsequent report indicating whether an internal child death review was completed.*

Please see the above response to Item 4.2. (8)

4.4 *As part of its instructions related to the outcome review process CDSS should direct county CWS agencies to include completed internal death reviews in the development of their self-assessments* and improvement plans.

The CDSS agrees that counties should document their internal death reviews as part of their overall assessment of the local child welfare services delivery system, when those cases identify systemic improvements that need to be made.

4.5 *As part of its oversight of the outcome review process CDSS should follow-up on whether Fresno and Sacramento counties implemented recommendations resulting from their respective internal death reviews.*

The CDSS concurs with this recommendation, and will follow up with these two counties to determine whether they have implemented the recommendations resulting from their internal child death reviews. Additionally, ongoing system improvements can be monitored through the Outcomes and Accountability quarterly monitoring of county performance and system improvements and incorporated in the counties' self-assessment and system improvement plan reports.

4.6 *To ensure that they report all requisite child deaths to CDSS and investigate all child death involving abuse or neglect, county CWS agencies should annually reconcile their child death information with other reliable information on child death, such as county child death review team data.*

The CDSS agrees with this recommendation, and in fact shares CWS information regarding children who have died as the result of abuse and neglect with the Department of Public Health on an annual basis to maintain its statewide child abuse and neglect fatality monitoring system.

Also, as noted above in Item 4.2, the CDSS will issue instructions to county CWS agencies to annually reconcile fatalities that the agency becomes aware of with other reliable child death information, including local child death review team death information, to ensure that all child fatalities resulting from abuse or neglect are reported to the state.

4.7 *To provide more useful information in its annual report, CDSS should provide child death information broken out by county, not just statewide totals; and, provide more analysis, such as comparing child death information over multiple years, and presenting child deaths as a percentage of the counties total child populations.*

(9) The CDSS disagrees with this recommendation. County-specific information already is available from each county, and each county is required to review fatalities and near-fatalities due to abuse or neglect. That analysis is best left to each county, for a local analysis of any systemic indicators that would require of the need for policy or practice changes on behalf of the county staff. The purpose of the state-level report is to analyze statewide trends and provide this information in the context of statewide policy.

The annual reporting process and product is still in its infancy. The state has only been producing the annual report per SB 39 for two years, and reporting requirements have varied throughout the years prior to enactment of SB 39. Therefore, at this time it is uncertain what additional information would prove valuable in understanding the commonalities in child fatalities that would allow for effective changes in policy or practice across the state. However, as more data becomes available, it is appropriate to expect that the CDSS and its county partners will be analyzing that data to develop any needed data reporting and policy changes.

As a final note, while any fatality is a tragic event, the incidence of fatalities is so low that percentage information would not be meaningful.

Separately from the items above, the CDSS would like to contribute additional considerations to the discussion surrounding Figure 5 on page 47:

> *"As Figure 5 shows, in the years that have passed since the UC Davis findings, the percentage of placements in foster family agencies has increased from 21 percent in July 2001 to 29 percent in July 2010. . . .We estimate that the growth in the percentage of placements with foster family agencies resulted in an additional $327 million in foster care payments between 2001 and 2010 ($61 million is 2010 alone)."*

(10) The CDSS notes that total costs for FFA placements have decreased from 2001 to 2010, in part due to the ten percent reduction in FFA grants effective in the 2009-10 fiscal year, even though in absolute numbers FFA placements remained relatively constant during this time period (increasing by one percent). Additionally, the State expected to see an increase in the percentage of FFA placements as a percentage of total placements during this time period because policy decisions, such as moving children from dependency to permanency through the Kinship Guardianship Assistance Payment (Kin-GAP) Program and Adoptions' initiatives, significantly reduced the number of FFH and group home placements during this same time period (FFA placements do not qualify for Kin-GAP).

# Comments

## CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF SOCIAL SERVICES

To provide clarity and perspective, we are commenting on the response to our audit report from the Department of Social Services (Social Services). The numbers below correspond to the numbers we placed in the margin of Social Services' response.

Social Services' summary of existing law is not entirely correct or complete. As we state in a footnote on page 24, current state law does not prohibit a person who is required to register as a sex offender as result of a juvenile court proceeding from living or working in licensed children's facilities or child welfare services (CWS) placements. As we state on the same page, registered sex offenders are not expressly prohibited from living in children's facilities or CWS placements similar to the residency prohibitions in Jessica's Law. If a registered sex offender is found improperly residing or working in a licensed facility or CWS placement, the facility or homeowner is required to expel the person or face having the license or home approval revoked or other penalties. However, the sex offender faces no consequences other than potential expulsion from the home or facility. For these reasons, we stand by our conclusion that examining current state laws related to registered sex offenders living or working in licensed children's facilities or CWS placements would be prudent. (1)

We believe this additional guidance is necessary because, when it had the opportunity to do so, Social Services did not provide these "existing requirements" during the audit. In fact, as of late September 2011, Social Services' Community Care Licensing Division agreed with our recommendation and described situations that it would want county CWS agencies to make it aware of that are not listed in Social Services' response. Social Services should reach internal agreement on what situations involving its licensees it wants to be made aware of and then provide clarification to county CWS agencies in its regulations. (2)

Social Services' response does not specifically address our recommendation that it analyze and establish support for each component of the rates paid to foster family agencies. Consequently, we are concerned that Social Services does not fully appreciate that establishing support for these rates—a portion of which is federally reimbursed—should be a high priority task that should be accomplished regardless of the timeline of any other reform effort. (3)

④ We believe that Social Services should expeditiously establish a requirement that county CWS agencies provide adequate justification for placements with foster family agencies and this action should not be dependent on the timeline of some larger reform effort.

⑤ As we state on page 37, Social Services' placement regulations do not require documentation of a determination that children have elevated treatment needs before placing them with higher cost foster family agencies. During our audit, the Social Services' official overseeing placements confirmed that county CWS agencies are not required by the regulations governing placements to document those decisions.

⑥ We stand behind our conclusion that measuring completed investigatory visits (absent attempts) is a critical measure of whether county CWS agencies are performing their responsibility to protect children. We also believe that Social Services' goal of 90 percent compliance with the immediate and 10-day requirements for investigatory visits discussed on page 49 allows for some attempted visits that do not result in actual in-person contact.

⑦ We disagree with Social Services' assertion that the "hold harmless" policy has no influence on overall caseloads. As stated on pages 54 and 55, the number of children in the CWS system has decreased by over 40 percent in the last 10 years but the hold harmless policy has held counties' funding for administration, which includes social worker salaries and benefits, to no less than previous year levels. With less children to oversee, but roughly the same number of social workers (because administrative funding did not decrease), the data indicates that caseloads have generally gone down—Sacramento being a notable exception.

⑧ Although Social Services agrees that county CWS agencies should perform internal death reviews and states that it will send out a letter encouraging the practice, it does not indicate it will create an ongoing mechanism, such as receiving reports on the number of death reviews completed, to determine whether county CWS agencies are taking its advice.

⑨ Senate Bill 39 requires Social Services' annual report to identify "any systemic issues or patterns" related to child abuse and neglect deaths in California. We believe that providing information on these deaths by county could improve Social Services' report by revealing important systemic issues or patterns. Social Services' assertion that this information is already available from the 58 counties does little to help state decision makers and stakeholders who may be

interested in this information. Social Services has this information by county readily available and could present this information in its annual report.

As we state on page 39, Social Services has not examined the foster family agency rates and has not created a requirement that county CWS agencies document their justification for placements with these higher-cost agencies. We estimate that the growth in the percentage of placements with foster family agencies resulted in an additional $327 million in foster care payments between 2001 and 2010 ($61 million in 2010 alone). ⑩

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
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Legislative Analyst
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