

Los Angeles County Department of Children and Family Services

Management Instability Hampered Efforts to
Better Protect Children

March 2012 Report 2011-101.2



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March 29, 2012

2011-101.2

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 Department of Children and Family Services (department), the department that provides services to abused and neglected children in Los Angeles County. This report concludes that instability in the department's management has hampered its efforts to address long-standing problems. Since 2009 the department has struggled to complete investigations of child abuse and neglect within requisite time frames. In July 2010 the department reported it had 9,300 investigations that were open longer than 30 days, the maximum time period allowed by state regulations. Although this backlog has decreased substantially, it remains at a relatively elevated level. Department officials indicated that it contributed to the backlog in uncompleted investigations when, under pressure from outside stakeholders, department management created new, potentially unrealistic policies that it later revised or rescinded in early 2011. Nevertheless, in January 2012 the backlog was still 3,200, more than twice as large as it was in July 2009.

The department has also struggled to perform required assessments of homes and caregivers prior to placing children with relatives. From 2008 to 2010 the department completed fewer than a third of home and caregiver assessments before placing children with relatives. This delay resulted in nearly 900 children living in placements that the department later determined to be unsafe or inappropriate. Even after these determinations, the children typically remained in these homes for nearly a month and half before the department removed them, or later reassessed and approved the placement. Department management failed to identify and address this long-standing problem because it has not monitored whether required assessments are completed prior to placement.

Finally, in just over a year, the department had four different directors. It has also experienced high turnover in other key management positions. This turnover impeded the department's ability to develop and implement a strategic plan that would have provided cohesiveness to its various initiatives and communicated a clear vision to department staff and external stakeholders.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

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Summary

RESULTS IN BRIEF

The Department of Children and Family Services (department)—the local agency responsible for protecting children from abuse and neglect in Los Angeles County—underperformed in the delivery of some key services, but it generally satisfied other state requirements. The department is required to begin and complete its investigations of abuse or neglect allegations (referrals) within certain time frames to ensure the safety of children. Although the department began most investigations on time, it struggled to complete many of them within requisite time frames. In July 2010 the department reported it had 9,300 investigations that were open longer than 30 days, the maximum time period allowed by state regulations. Although this backlog has decreased substantially, in January 2012 it was still 3,200, more than twice as large as it was in July 2009.

After a referral is substantiated, it can become a case, and social workers are then required to visit monthly with a child and family until safety and other concerns are resolved. To best accomplish the purposes of these visits (for example, monitoring the child's safety), social workers should conduct these visits in the home. The department's policy confirms this thought, stating that visits outside the home should be the exception instead of the rule. The department generally conducted these ongoing case visits; however, they occurred outside the children's homes for three or more consecutive months in seven of the 30 cases we reviewed.

Both investigatory and ongoing visits can lead to a social worker removing a child from a home. If this occurs, the social worker needs to find an out-of-home placement for the child. Although the California Department of Social Services (Social Services) licenses foster homes in Los Angeles County, the county department is responsible for completing required home assessments and criminal background checks before placing children with relatives. Placing children in unassessed homes potentially exposes them to dangerous people and environments. Our review of 20 placements found that the department, in nine instances, did not complete required assessments and background checks before placing children with relatives. Our analysis of department data further indicate that the department placed a large number of children with relatives before the department's home assessment unit determined whether the placements were safe and appropriate. From 2008 to 2010, the department completed required assessments of less than 31 percent of homes and caregivers before placing children with relatives. This delay resulted in nearly 900 children living in placements that the department later determined to be unsafe or inappropriate. Even after these determinations, these children

Audit Highlights . . .

Our review of the Los Angeles County Department of Children and Family Services (department), highlighted the following:

- » *Although the department began most investigations on time, it struggled to complete many of them within requisite time frames.*
- » *To best monitor a child's safety, monthly visits with a child and family should be in the home, yet for three or more consecutive months in seven of the 30 cases we reviewed, visits occurred outside the children's homes.*
- » *Of 20 placements that we reviewed, we found that the department, in nine instances, did not complete required assessments and background checks before placing children with relatives.*
- » *Delays in the department completing required assessments of homes and caregivers resulted in nearly 900 children living in relative placements that the department later determined to be unsafe or inappropriate.*
- » *Although the department generally acted quickly to remove children from potentially unsafe placements, it did not always notify requisite oversight entities of allegations of abuse or neglect.*
- » *A general instability in management has hampered the department's ability to address its long-standing problems such as completing timely investigations and placement assessments.*
- » *The turnover in key management positions has impeded the department's ability to develop and implement a strategic plan.*

typically remained in the homes for nearly a month and a half before the department removed them or reassessed and approved the placement.

Further, our analysis of department data indicated that not completing timely investigations and placement assessments has been a long-standing problem. To address this problem, the department developed internal policies and performance measures that allowed it to complete investigations within 60 days (instead of the 30 days required in regulation) and to complete required assessments within 30 days of social workers notifying the department's home assessment unit of a placement (instead of before placement, as required in state law). Although the department obtained temporary approval from Social Services for its 60-day investigatory time frame, we believe that these policies and measurements have not served the department well in its efforts to improve the timeliness of its services and provide for the safety of children.

In response to findings from our office's October 2011 child welfare services (CWS) report,¹ Social Services directed the department to follow up on 126 referrals in which the registered addresses of sex offenders matched the address of a child in a CWS placement in Los Angeles County. As a result of its investigations, the department remedied three situations in which children were living with sex offenders by having the sex offender removed or by removing the child from the home. The investigations also resulted in the correction of sex offenders' addresses and numerous social-worker-to-family dialogues about who may associate with children in the CWS system. This success in protecting children from sex offenders highlights the positive results that can ensue from Social Services using information available to it.

Although the department generally acted quickly to remove children from potentially unsafe placements, it did not always notify requisite oversight entities of allegations of abuse or neglect. Until recently, it was required to notify the California Department of Justice (DOJ) of all alleged abuse when a social worker determines that allegations of physical abuse are either substantiated or inconclusive. However, the department submitted reports to DOJ for only three of the eight cases we reviewed that required such a report. By not submitting these reports, the department has limited its ability to later use DOJ's database to ensure that children are placed only in safe environments.

¹ *Child Welfare Services: California Can and Must Provide Better Protection and Support for Abused and Neglected Children* (2011-101.1).

A general instability in management has hampered the department's ability to address its long-standing problems. Department officials pointed to a period of time when new, potentially unrealistic policies were being created at a rapid pace in response to pressure from outside stakeholders. These policies contributed to a backlog of uncompleted investigations and were eventually revised or rescinded. Such events speak to a pattern, identified by an external management consultant over a decade ago, of intense pressure from numerous stakeholders and the difficulty this large department has had staying on one unified course. In just over a year, the department had four different directors, and it has experienced high turnover in other key management positions as well. The turnover has impeded the department's ability to develop and implement a strategic plan that would have provided cohesiveness to its various initiatives and communicated a clear vision to department staff and external stakeholders.

Despite its problems, numerous indicators point to a department positioned to overcome its challenges. The county's board of supervisors has hired a permanent director who recently moved forward, with input from staff, on a strategic plan that lays out a long-term course for the department. Additionally, while the annual turnover rate for key management positions over the five years we reviewed was 25 percent, it was only 4 percent for the department as a whole. National statistics for state and local government employees pegged turnover at 16 percent for the same time period. We also found that the number of cases per worker (caseload), while not at ideal levels, have been consistently lower than caseload targets established in the department's labor agreements. Finally, even though the department may have some problems localized in certain regions and work units, employees responding to our survey were generally positive about their work environment.

Recommendations

To ensure that child abuse and neglect allegations receive timely resolution, the department should do the following:

- Continue to monitor the status of its backlog of investigations but revise its policies and performance measures to no longer define the backlog as investigations over 60 days old. Rather, it should emphasize completing investigations within 30 days.
- Assess whether it needs to permanently allocate more resources to investigate allegations of child abuse and neglect.

To ensure that it is placing children only in safe homes, the department should measure its performance and adjust its practices to adhere to state law, which requires that all homes and caregivers be assessed prior to the placement of the child.

To ensure that social workers have as much relevant information as possible when placing children and licensing homes, the department should report allegations of abuse and neglect to DOJ and Social Services' licensing division, when required to do so.

To create and communicate its philosophy and plans, the department should complete and implement its strategic plan.

Agency Comments

The department responded that they generally agreed with our findings and recommendations. However, the department disagreed with our finding that it often places children with relatives before conducting required home and caregiver assessments. The department believes it performed these assessments in accordance with its interpretation of state law. As we describe in our comments to their response, the department's interpretation of state law is incorrect and appears to be based on a misleading and incomplete summary of relevant statutes.

Introduction

Background

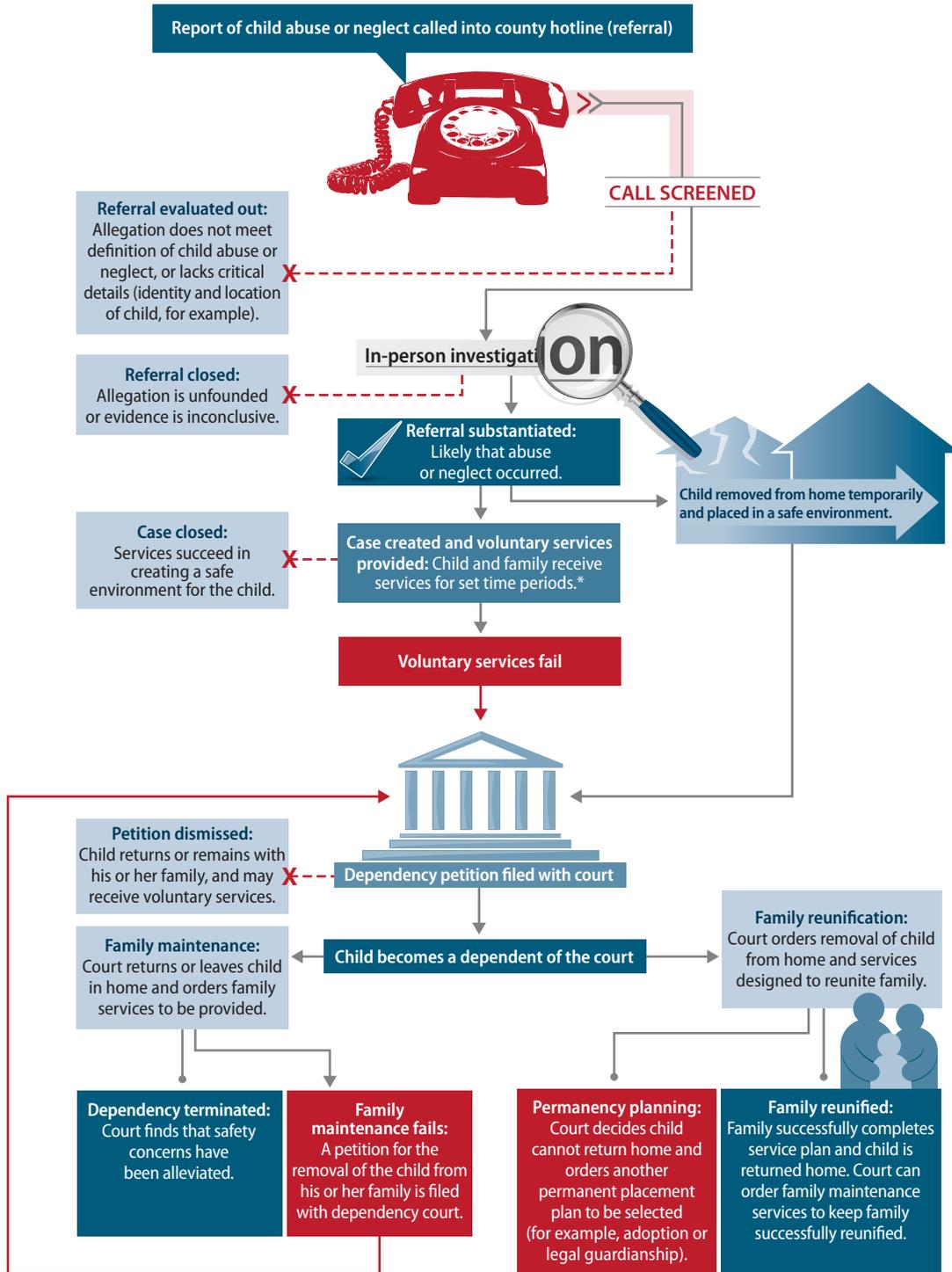
The Los Angeles County Department of Children and Family Services (department)—under the purview of the Los Angeles County board of supervisors and California Department of Social Services (Social Services)—is tasked with preventing and responding to child abuse and neglect in Los Angeles County. With over \$1 billion in funding from local, state, and federal governments and approximately 7,000 employees, the department provides services to children and families, including responding to the more than 80,000 reports of abuse and neglect that it receives every year. Generally, the department provides family preservation services, removes children from unsafe homes, temporarily places these children with relatives or in foster homes, and facilitates legal guardianship or adoption of these children into permanent families when appropriate.

Process of Delivering Services to Children and Families

As depicted in Figure 1 on the following page, the department's process for delivering services to children and families who are at risk for abuse and neglect typically begins when the department receives an allegation of suspected child abuse or neglect (referral) on its child abuse hotline. The call is screened by a social worker, who assesses the risk to the child. Based on the risk assessment, the social worker determines whether to evaluate out the referral (take no further action) or to have a social worker investigate the referral in person within a specific number of days, by the end of the investigating social worker's shift, or as soon as possible. Referrals from law enforcement must be investigated in person and cannot be evaluated out unless law enforcement has already investigated and found no indication of abuse or neglect. State law requires an immediate in-person response in all situations in which a child is in imminent danger of physical pain, injury, disability, severe emotional harm, or death. While state law requires an in-person investigation within 10 days when a child is not in imminent danger, department policy specifies that this action must take place within five business days.

If the department determines through its investigation that the allegation of abuse or neglect is unfounded, or if evidence is inconclusive, it closes the referral. The department indicated that even when it closes a referral, it may refer families to other community resources. If it substantiates a report of abuse or neglect, the department can either allow the child to remain at home while voluntary services are provided or temporarily remove the child from the home and place him or her in a safe environment

Figure 1
Major Components and Processes of Los Angeles County's 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.

(depending on the nature of the abuse or neglect). State regulation requires the department to either close or substantiate all referrals within 30 calendar days of beginning its in-person investigation, removing a child, or having a juvenile court hearing, whichever comes first. As discussed in Chapter 1, the department received a temporary waiver from Social Services in August 2010 extending this time frame to 60 calendar days.

When the department or law enforcement removes a child from the care of a parent or guardian, the department places the child in temporary custody. If it believes continued custody is necessary for the child's protection, the department 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.

When a court declares a child a dependent of the court, it may allow the child to remain at home and order the department to provide family maintenance services. Alternatively, the court may order a child removed from the custody of the parent or guardian. In this situation, 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 will order the department to supervise the child's care. The department may then place the dependent child, in order of priority, with relatives, with extended-family members, in a foster home, or in another suitable community care facility, such as a group home (see text box).

Common Types of Out-of-Home Care in the Child Welfare Services System, in Order of Priority

- Noncustodial parent
- Relative or extended family member
- Foster home
- Group home

Source: California Department of Social Services' regulations.

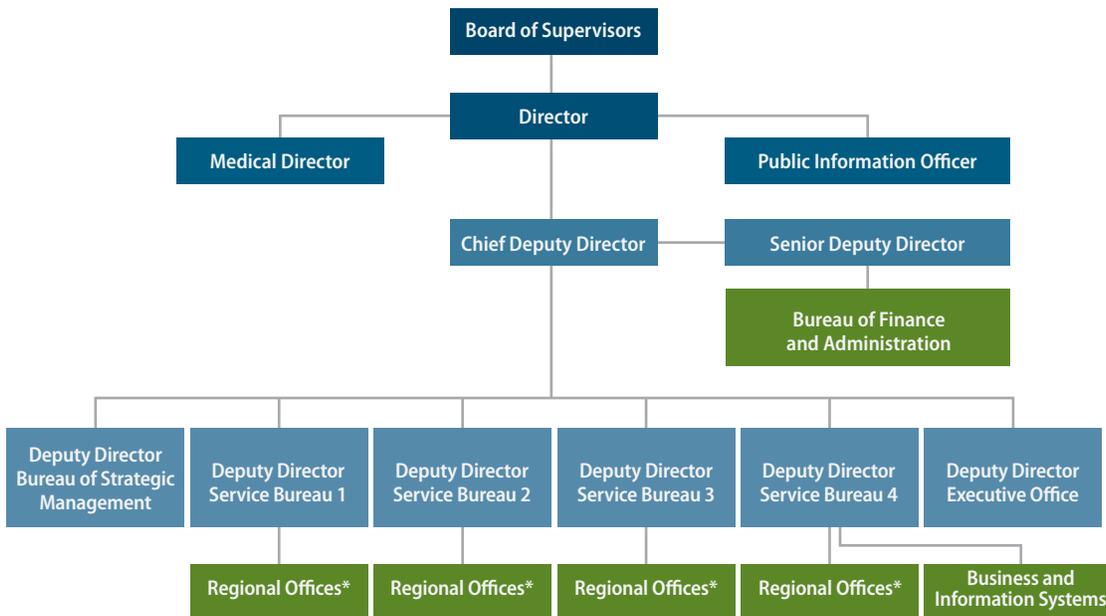
The social worker and family jointly develop a case plan to meet the needs of the family and address any safety concerns about the home environment. The department must provide permanent placement services for children who cannot safely live with their parents and are not likely to return home. The court 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.

Organizational Structure of the Department

The department, which reports directly to the county's board of supervisors, is organized into various bureaus and offices. Most of the department's employees work in one of the service bureaus shown in Figure 2 on the following page. The service bureaus oversee multiple regional offices, and each regional office is led by a regional administrator and assistant regional administrators. The assistant

regional administrators lead units of employees who investigate allegations of abuse and neglect, remove children from unsafe homes, and deliver various services to children and families (social workers). In addition to the deputy directors who lead the service bureaus, the department has a deputy director who leads its executive office and one who leads its strategic management bureau. The deputy director of the executive office oversees the department’s hotline center and child death reviews. The department also has a chief medical officer who oversees various programs, including the sensitive case unit that handles celebrity and employee referrals.

Figure 2
 Los Angeles County Department of Children and Family Services



Source: Los Angeles County Department of Children and Family Services.

* Each regional office is responsible for providing four of the department’s five service components—emergency response, family maintenance, family reunification, and permanency planning—within a certain geographic area.

Departmental Funding

The department’s expenditures have increased steadily over the past six years, as shown in Table 1. The department has been able to maintain this level of expenditures—while other county child welfare services (CWS) agencies are struggling—because it is involved in a federal demonstration project that allows it to accumulate and later spend certain reserve funds. Los Angeles County is one of two counties in California that participate in the federal government’s Title IV-E waiver program (waiver program), which started on July 1, 2007,

and is slated to end on June 30, 2012. Under the waiver program, Los Angeles 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. Because the number of children in Los Angeles County’s CWS program has decreased, the department had unspent funds at the end of some fiscal years. The waiver program allows the department to carry these unspent funds (reserve funds) forward to the subsequent year for reinvestment in the CWS program. For example, at the end of fiscal year 2010–11, Los Angeles County had reserve funds amounting to \$64.7 million. With its reserve funds, the department has been able to fund elective programs, such as expanded use of team decision-making meetings, which involve social workers, relatives, and others in developing plans for children.

Table 1
Los Angeles County Child Welfare Services’ Expenditures
(in Millions)

| FISCAL YEAR | CASEWORKER COSTS* | ADMINISTRATIVE/ CLERICAL COSTS† | OPERATING COSTS‡ | DIRECT COSTS§ | OTHER | TOTALS |
|-------------|-------------------|---------------------------------|------------------|---------------|--------|---------|
| 2005–06 | \$261.0 | \$116.6 | \$106.5 | \$23.5 | \$33.2 | \$540.8 |
| 2006–07 | 282.1 | 128.2 | 99.1 | 25.6 | 36.6 | 571.6 |
| 2007–08 | 301.8 | 144.0 | 100.5 | 28.2 | 31.4 | 605.9 |
| 2008–09 | 312.8 | 155.6 | 109.4 | 35.4 | 34.0 | 647.2 |
| 2009–10 | 344.0 | 166.1 | 115.2 | 41.9 | 35.7 | 702.9 |
| 2010–11# | 361.3 | 171.6 | 116.1 | 53.9 | 44.8 | 747.7 |

Source: California Department of Social Services’ (Social Services) county expense claim system records for Los Angeles County.

Notes: The table does not include direct payments made primarily to out-of-home care providers (for example, foster family agencies, foster family homes, and group homes), which ranged from a high of \$517.2 million in fiscal year 2005–06 to a low of \$445.1 million in fiscal year 2010–11.

According to Social Services’ county expense claims manual, the above columns refer to the following:

- * Salaries and benefits of caseworkers and their first-line supervisors.
- † General administration, program administration, and clerical staff.
- ‡ Includes expenditures for travel, space, telephones, supplies.
- § Costs that directly benefit only a single child welfare services program and may include start-up and one-time-only costs that cannot be equitably distributed via the normal cost-allocation process.
- || Includes information technology and staff development costs.
- # Expenditure totals for the third and fourth quarters of fiscal year 2010–11 are based on preliminary numbers provided by the Los Angeles County Department of Children and Family Services to Social Services.

The department has also been able to use its reserve funds resulting from the waiver program to weather state budget cuts. To reduce the State’s budget deficit, the governor cut \$80 million in CWS funds in fiscal year 2009–10. Los Angeles County’s share of this budget reduction was roughly \$17.1 million. After using its reserve funds to

absorb its share of the cut, Los Angeles County still had a reserve of \$74.9 million for fiscal year 2009–10. This funding reduction continued into fiscal year 2010–11, and Los Angeles County was again able to use its reserves to mitigate the impact of this budget reduction.

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) asked the California State Auditor (state auditor) to review four county CWS agencies in various regions of the State. We selected four counties—Alameda, Fresno, Los Angeles, and Sacramento—based on several factors, including the county’s size, population, geography, and number of child abuse and neglect allegations. The audit committee also asked the state auditor to review Social Services’ role in providing county CWS agencies guidance and assistance and in monitoring their compliance with applicable policies and procedures. In October 2011 we produced a report regarding our review of Social Services and the CWS agencies in Alameda, Fresno, and Sacramento counties (October 2011 report).² Because Los Angeles County initially refused us access to certain records necessary for our audit, we had to delay our audit work related to its CWS agency. We subsequently gained access to these documents and completed the work requested by the audit committee.

In summary, the audit committee asked us to look at the department’s expenditures, investigatory and case management practices, placement of children in out-of-home residences (placements), removal of children from inappropriate placements, child deaths and death reviews, and social worker caseloads.

With regard to department expenditures, the audit committee asked us to identify the major categories of CWS expenditures for the past five years. We provide this information in Table 1 on the previous page. To produce this information, we obtained expenditure records from county expense claims. We then verified that the county’s administrator and auditor certified the accuracy of the expense claims.

To examine the department’s investigatory practices, we reviewed 30 referrals for compliance with its policies and procedures, as well as state regulations. We also reviewed 30 cases to determine whether the department performed required visits. The results of our testing, as well as department data and perspective, are

² *Child Welfare Services: California Can and Must Provide Better Protection and Support for Abused and Neglected Children* (2011-101.1).

provided in Chapter 1. In Appendix A, we provide statistical information on the number of referrals received and investigations completed that was specifically requested by the audit committee.

To examine its placement practices, we determined whether the department complied with state regulations and department policy for 20 placements with relatives or extended-family members. We did not evaluate department compliance for placements with foster family agencies, foster family homes, or group homes, because Social Services is responsible for licensing or certifying these facilities in Los Angeles County. In our October 2011 report, we examine Social Services' oversight of its licensed facilities. To examine the department's timeliness in removing children from inappropriate foster homes, we reviewed 20 instances in which the department removed a child from placement because of a complaint against a caregiver. Results regarding the department's placement practices can be found in Chapter 2 and Appendix B.

At the request of the audit committee we provide, in Appendix C, specific information related to child deaths in Los Angeles County. We obtained this information from a department report and verified the reliability of this report using information from 25 child deaths that we reviewed. Using the same 25 child deaths, we examined the department's process for performing a self-evaluation subsequent to each death (death review). We reviewed the department's child death review documents and child death statistics, as well as information in Social Services' Child Welfare Services/Case Management System (CWS/CMS). We also interviewed employees involved with the department's child death review process. The results of our review of this process can be found in Chapter 2.

To provide information on cases per social worker, we used data from the CWS/CMS to calculate an average caseload for the department. To determine the number of cases a social worker held, we identified the social worker with primary assignment for a hotline call, a referral investigation (emergency response investigation), or a case during the last month of each quarter between 2006 and 2010. We included only those cases requiring the department to provide services and did not include emergency response investigations for which the referrals had been evaluated out. To calculate the effective number of cases and emergency response investigations a social worker held, we counted the number of days a social worker held the case or emergency response investigation 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 were transferred from one social 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 department during each month measured. To account for

social workers who have cases in multiple service components, where each service component has its own standard, we prorated our counting of social 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. Although these estimates were developed over a decade ago, they are the most recently published workload measurements. We excluded certain employees, such as clerks, interns, 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 this total by our calculated number of social 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. 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. This assessment is described in our October 2011 report. As detailed in our previous report, 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 social worker's visit; and the counties' workload. We also conducted an additional analysis not performed in the previous report. Specifically, we used CWS/CMS to calculate the average number of days that elapsed between the date of a relative home assessment and the start and end dates of the placement with relatives. Further, we calculated the number of these assessments that found the home did not meet the standards for foster care. Because the need for this analysis was not identified until after the conclusion of fieldwork, it was not feasible to conduct data reliability testing for this purpose.

Audit standards require us to examine the department's processes designed to ensure compliance with applicable laws and other requirements (internal controls), including whether management and employees have established a positive and supportive attitude toward internal controls (control environment). Because Los Angeles County withheld for a time certain documents related to child deaths, and because we were aware that the department had experienced high turnover in key management positions, we had concerns regarding the control environment within the department. To address our concerns, we performed additional audit procedures, surveying all department employees regarding internal controls and reviewing the turnover in key management positions. We provide the results of these additional audit procedures in Chapter 3 and in Appendix D.

Chapter 1

THE DEPARTMENT STRUGGLED TO COMPLETE TIMELY INVESTIGATIONS BUT GENERALLY FULFILLED OTHER VISITATION REQUIREMENTS

Chapter Summary

The Los Angeles County Department of Children and Family Services (department) performed many of its required activities in compliance with state law, regulations, department policy, and best practices. For example, it generally began investigations on time, conducted ongoing case visits, and used required assessment tools. Even so, the department has struggled to complete investigations of child abuse and neglect in a timely manner. The development and implementation of new policies contributed to the creation of a large backlog of uncompleted investigations, which peaked in July 2010 but continues to be a problem. Rather than just confront its practice and resource constraints causing untimely services, the department redefined the problem on more favorable terms by requesting and obtaining a temporary exemption from the California Department of Social Services (Social Services) allowing it to complete investigations within 60 days instead of 30.

Although the Department Generally Began Investigations Promptly, It Did Not Complete Investigations Within Required Time Frames

Although its investigations of child abuse referrals usually began in a timely manner, the department struggled to complete its investigations within required time frames. It failed to complete 16 of the 30 referrals we reviewed on time. According to its systemwide data, the department experienced a rapid increase in investigations remaining open beyond 30 days beginning in July 2009 (1,400 unclosed investigations) and peaking in July 2010 (9,300 unclosed investigations). Initially sparked by policy changes that made completion of investigations more difficult, this backlog has since been reduced by policy revisions and additional resources. Nonetheless, the backlog still totaled 3,200 uncompleted investigations as of January 2012. Finally, we found, based on our testing of 30 referrals, that the department's social workers have generally used appropriate tools to assess children's safety and obtained required supervisory reviews.

The Department Usually Began Its Investigations of Referrals in a Timely Manner

We concluded, based on our review of 30 referrals and our analysis of department data, that the department usually began its investigations of allegations of child abuse or neglect (referrals) within required time frames. Even so, the department still has room for improvement, especially in its response to referrals requiring an immediate response. When the department receives referrals, state regulations require it to perform an in-person investigatory visit either immediately or within 10 days, depending on the severity of the allegation.³ The department's policies are even more stringent, requiring investigations to begin either immediately or within five days.

Of the 18 immediate-response referrals that we reviewed, the department began 16 investigations within 24 hours. For both of the investigations that it failed to begin within the required time frame, the department attempted to make an in-person contact within the first 24 hours. Of the 12 five-day referrals that we reviewed, the department began seven investigations within the department guideline of five days. It complied with state regulations—making in-person contact within 10 days—for 10 of the 12 referrals. For the other two referrals, social workers attempted to make contact during the first 10 days; however, they did not successfully make in-person contact with the family until the 12th day in one instance and the 15th day in the other.

Table 2 presents our analysis of department and statewide data on the timeliness of investigations for all immediate and 10-day referrals for 2006 through 2010.⁴ As indicated in the table, the department's immediate investigation rates have generally improved over time, but they are still below the statewide average. In contrast, its compliance with requirements for investigating 10-day referrals has been significantly higher than the applicable statewide average, likely due to the department's efforts to investigate these types of referrals within a five-day period. A deputy director stated that the department struggled to make in-person investigatory visits due to its massive backlog of unclosed investigations.

The department's immediate investigation rates have generally improved over time, but they are still below the statewide average.

³ State regulations do not define the exact time frame of an immediate response. As discussed in the Introduction, department policy defines an immediate response as occurring by the end of the investigating social worker's shift, or as soon as possible. Because we had limited ability to determine when an employee's shift ended, we examined whether the department responded within 24 hours for the immediate-response referrals we reviewed.

⁴ Appendix A presents the number and disposition of all reports of abuse and neglect in Los Angeles County for 2006 through 2010.

Table 2
Percentage of Investigatory Visits Occurring Within Required Time Frames
2006 Through 2010

| YEAR | LOS ANGELES | | STATEWIDE | |
|------|-------------|---------|-----------|---------|
| | IMMEDIATE | 10 DAYS | IMMEDIATE | 10 DAYS |
| 2006 | 83% | 84% | 88% | 70% |
| 2007 | 83 | 83 | 88 | 70 |
| 2008 | 85 | 85 | 89 | 73 |
| 2009 | 87 | 86 | 91 | 73 |
| 2010 | 86 | 81 | 90 | 68 |

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

Note: As measured here, a social worker begins investigating a referral when he or she completes an in-person contact. Unsuccessful attempts are not included in this table.

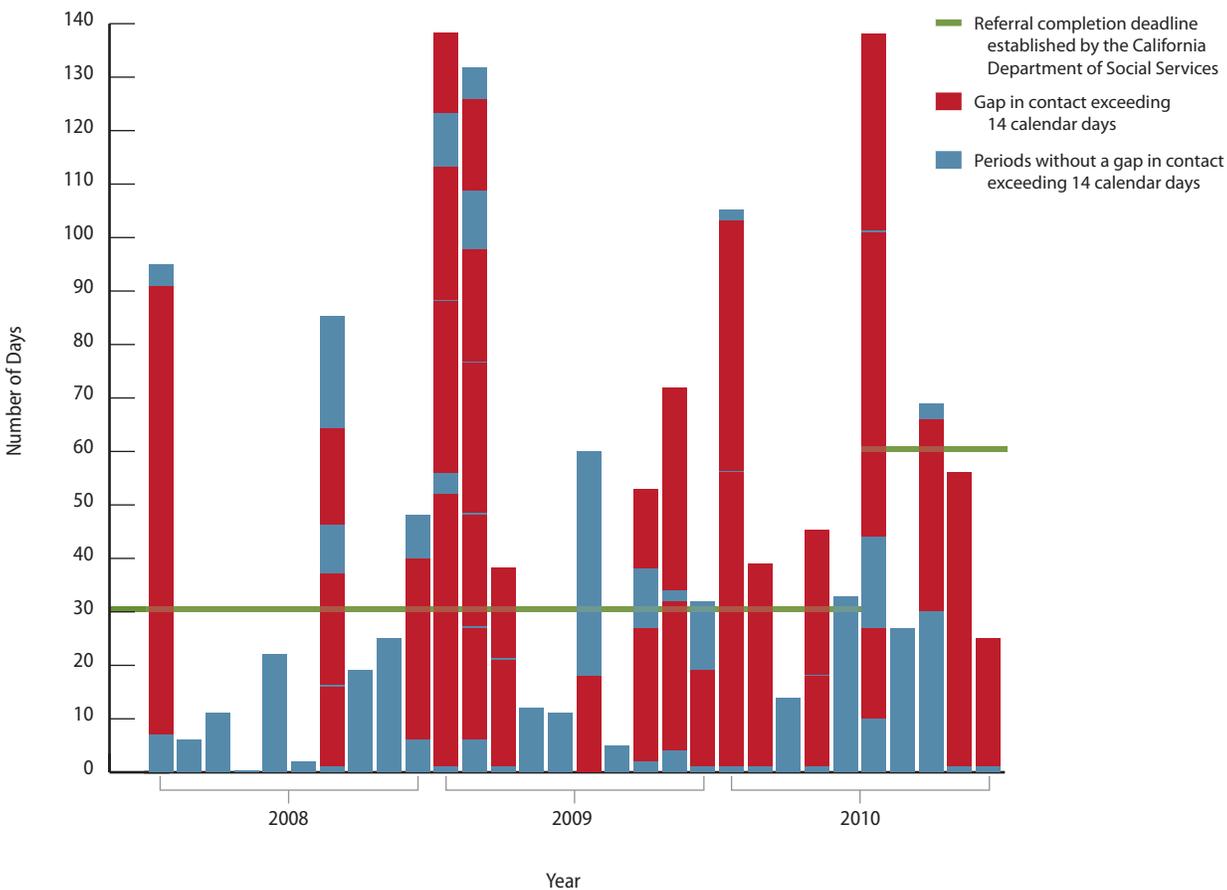
The Department Often Did Not Complete Its Investigations of Child Abuse or Neglect Within Required Time Frames

The department has struggled to complete its investigations of referrals within the number of days specified by Social Services. As a result, its backlog of uncompleted investigations grew to historically high levels in July 2010. Although the backlog has subsequently decreased, it remains at elevated levels. State regulation requires a social worker—once he or she has begun an investigation—to complete it within 30 calendar days. Beginning in July 2009, the department experienced a rapid increase in the number of investigations remaining open beyond 30 days. In April 2010 the department requested that Social Services temporarily modify this requirement for Los Angeles County, extending the time frame to complete investigations from 30 to 60 days. In its letter requesting the temporary modification, the department stated it would use the additional time to provide a higher level of management involvement and allow staff more time to work with families. In August 2010 Social Services granted this request, extending the department's time frame for closing an investigation to 60 days for all referrals received between July 1, 2010, and June 30, 2013.

As shown in Figure 3 on the following page, the department was unable to investigate and close most of the 30 referrals that we reviewed within the requisite time periods. The department did not complete its investigation within 30 days for 14 of the 25 referrals it received between January 2008 and June 2010 that we selected. The department also did not complete its investigation within 60 days for two of the five referrals it received between July 2010 and December 2010 that we selected. Additionally, 17 of our 30 selected

investigations had gaps of 14 days or longer during which we found no evidence of social workers performing any activity to investigate the referrals. A deputy director stated that these gaps in contact likely resulted from social workers maintaining high caseloads and a departmental emphasis on assessing new referrals before closing older ones. The deputy director told us that once a social worker completes a safety assessment on a referral and determines that a child is not in any imminent danger, the social worker may not provide the older referral as much attention as a new referral. Therefore, the response to an earlier referral may contain a gap in contact during which the social worker is handling new, higher priority referrals.

Figure 3
 Number of Days It Took Social Workers to Finish Investigation of 30 Selected Referrals
 2008 Through 2010



Source: California State Auditor's analysis of 30 selected referrals obtained from the Los Angeles County Department of Children and Family Services.

As part of the agreement with Social Services to temporarily extend the time frame to close investigations from 30 to 60 days, the department agreed to conduct additional investigatory visits. Within the first 21 days of a referral being opened, a social worker was required to make three in-person contacts with each child, instead of three in-person contacts within 30 days.⁵ Additionally, the department committed its social workers to making at least one additional contact with each child if a referral stays open longer than 30 days. For four of the five referrals received between July 2010 and December 2010 that we reviewed, the department made only one visit within the first 21 days. For the fifth referral the department made two visits within the first 21 days. Moreover, although four of the five referrals were open longer than 30 days, only two received the additional visit called for in the department's agreement with Social Services. The Social Services agreement also recommended that department social workers make one additional contact with parents who have access to the child if the referral stays open more than 30 days. However, in three of the five referrals that we reviewed, this additional contact was not made. A department deputy director acknowledged that the department did not emphasize the new requirements and did not notify social workers of the requirements until several months after they were in place. The deputy director added that the department had a large backlog of unclosed investigations and that enforcing new requirements on social workers already struggling to meet the original contact requirements would have been difficult.

Although four of the five referrals were open longer than 30 days, only two received the additional visit called for in the department's agreement with Social Services.

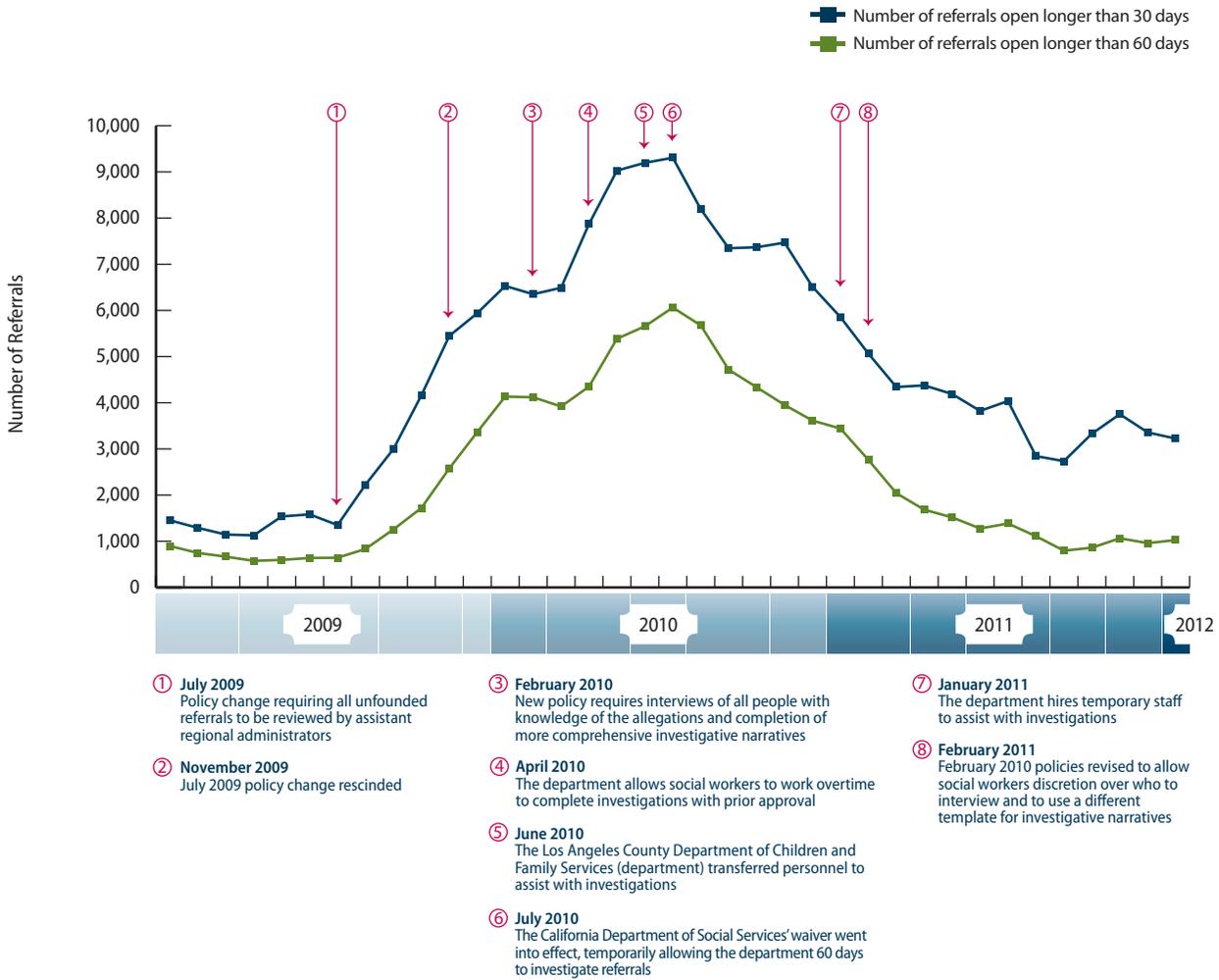
New Department Policies Contributed to the Backlog

The department provided statistics, shown in Figure 4 on the following page, indicating that the results from the 30 referrals we reviewed are representative of its recent performance. The data confirm that the department's backlog of uncompleted investigations was increasing rapidly prior to its April 2010 request to increase the number of days required to complete an investigation. Combined with the department's lack of emphasis on the requirements for additional visits agreed upon with Social Services, the 60-day waiver request appears to have been aimed more at redefining an existing problem under more favorable terms than providing better services. Although Figure 4 indicates that

⁵ In a February 2011 letter, the department stated to Social Services that it had inadvertently proposed three in-person contacts for each child during the first 21 days of the investigation. Instead, the department proposed providing two contacts within 21 days and a total of three contacts within 30 days. In its September 2011 response to the department, Social Services agreed to this modification. Because our review covered referrals made prior to this modification, we analyzed whether the department completed three contacts within 21 days.

the department has significantly decreased its backlog since the peak in July 2010, it also shows that more than 3,200 referrals had not been closed within 30 days as of January 2012.

Figure 4
Investigations of Referrals Open Longer Than 30 Days and 60 Days
January 2009 Through January 2012



Source: California State Auditor's analysis of unaudited data obtained from the department.

To determine the reason for the backlog, we interviewed numerous former and current department officials. They pointed to changes in policies that occurred in 2009 and 2010, and to social workers leaving certain regional offices. The policy changes placed additional requirements

on social workers who investigate referrals. Over time, management realized that these new policies were contributing to the backlog, and revised or rescinded them. These policies include the following:

- In July 2009 the department director distributed a memo requiring approval from assistant regional administrators—in addition to supervisory review—before a social worker could close a referral as being unfounded. In November 2009 the department rescinded this policy.
- In February 2010 the department created a policy that social workers must interview all, but no fewer than three, pertinent people in each investigation who could help in understanding the nature and extent of the allegation and in assessing the risk to and safety of the children. In February 2011 the department revised this policy to allow social workers to base the number of people they interview on case circumstances and their professional judgment.
- In February 2010 the department created a policy that social workers must write more comprehensive investigative narratives. In February 2011 the department revised its investigative narrative template, making many fields prepopulated. According to the department, this change provided social workers more time to write comprehensive investigative narratives.

An acting deputy director stated that these policy changes resulted from the department's desire to better protect children and from pressure from the media and board of supervisors. She explained that in hindsight, the speed and reach of these policy changes may have outpaced the department's ability to handle such changes effectively. A former director of the department stated that these policies were an attempt to provide an ideal level of service; however, the department did not always have the resources to perform these ideal service levels. The former director added that media scrutiny resulted in a general sense of fear among staff and that this fear led to paralysis in decision making, manifesting itself in an increasing number of referrals that staff were holding open.

A department official also pointed out that large backlogs at certain regional offices—caused by high turnover rates among social workers—further inflated the department's overall backlog numbers. According to data provided by the department, between July 2009 and November 2011, the department's Compton, Vermont Corridor, and Wateridge regional offices had a monthly average of 540 uncompleted investigations after 30 days. This figure was three times higher than the average at the other regional offices. In the first three months of 2011, despite starting to decrease its backlog, the Compton office had an average of more than 800 uncompleted investigations that were over 30 days old, more than four times the average of other regional offices.

A former director indicated that media scrutiny resulted in a general sense of fear among staff and an increased number of referrals staff were holding open.

According to the deputy director in charge of the regions, these three regional offices serve inner-city areas that provide more challenges for social workers than other regional offices. As a result, social workers in these inner-city offices often transfer to other regional offices after completing the one year of mandatory service the department requires of all newly hired social workers before allowing them to transfer to another regional office. Further, the social workers in these inner-city offices are often newly employed, with less experience, and they cannot, per their labor agreements, handle as many cases as more experienced workers. The deputy director added that the cases of social workers who are leaving must be transferred to new social workers, which negatively affects clients and social worker performance. In a November 2010 report, the county's chief executive officer identified the lack of experienced social workers in certain regional offices as the cause of their underperformance. The report also stated that high stress levels at these offices contribute to the high turnover rate. In the Compton regional office, for example, the report found that the high turnover rate had resulted in approximately 29 percent of its social workers having less than two years of experience.

The department has taken steps to reduce its backlog of uncompleted investigations, including increasing staffing and changing policies that may have contributed to the backlog. Department officials stated that in June 2010, the department transferred personnel from other programs to its emergency response division, the division responsible for investigating referrals. In January 2011 the department began hiring temporary staff to investigate referrals. Department officials also stated that in April 2010 the department asked for volunteers willing to work overtime to help investigate and close referrals. As shown in Figure 4 on page 18, the department's statistics indicate that it has been able to reduce the backlog of investigations. Nonetheless, a substantial number of referrals that are 30 or 60 days old still need to be completed. To address this issue, we believe the department needs to eliminate the expectation created by the 60-day waiver and return to the standard of 30 days that all other counties attempt to follow, and to adjust its resources and practices to generally complete investigations within the required time frame.⁶

Although the department has taken steps to reduce its backlog of uncompleted investigations, a substantial number of referrals that are 30 or 60 days old still need to be completed.

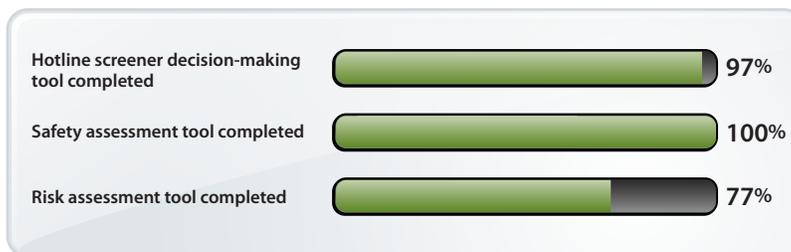
⁶ As we indicate in our October 2011 report, *Child Welfare Services: California Can and Must Provide Better Protection for Abused and Neglected Children* (2011-101.1), we do not advocate rigid compliance with the 30-day-closure requirement. We acknowledge that social workers sometimes hold investigations open to receive important additional evidence, such as physician reports, and we appreciate the balance social workers must strike between avoiding case backlogs and taking the time necessary to ensure that children are best served.

The Department Generally Met Requirements for Supervisory Review of Allegations and the Use of Appropriate Tools to Assess Risk and Safety

The department generally satisfied state and departmental requirements for supervisory review of allegations and social workers' use of tools that assess children's safety risks. After a department employee receives an allegation and then classifies it as requiring either an immediate or a five-day response, state regulation requires a supervisor to review and approve the classification. Supervisory review is intended to ensure that the department appropriately responds to allegations. Our review of 30 referrals found that supervisors had reviewed 29.

Departmental policies require social workers to use specific assessment tools for various tasks. The department uses the tools to determine the time frame within which to begin investigations and to assess a child's risk and safety in a given environment. As shown in Figure 5, the department used two tools for almost all of the 30 referrals we reviewed. It did not use the risk assessment tool as regularly, using the tool for 23 of the 30 referrals we reviewed. One of its deputy directors stated that the department has recently used the risk assessment tools more regularly because a policy change in 2009 required social workers to use the tools for all referrals.

Figure 5
Use of the Structured Decision-Making Tools
2008 Through 2010



Source: California State Auditor's review of 30 randomly selected referrals at the Los Angeles County Department of Children and Family Services.

Although the Department Generally Conducted Ongoing Case Visits, Several Consecutive Visits Occurred Outside Children's Homes

Our review of 30 cases found that the department generally met Social Services' standard for ongoing visits. State regulations typically require social workers to visit children in the child welfare

services (CWS) system at least once each month. As described in our October 2011 report, Social Services established a standard of 90 percent compliance with this requirement for ongoing visits.⁷ As shown in Figure 6, the department consistently surpassed the compliance standard.

Figure 6
Percentage of Required Ongoing Visits Made
2008 Through 2010



Source: California State Auditor's review of 327 required visits associated with 30 selected cases (10 per year) at the Los Angeles County Department of Children and Family Services.

The 2010 decrease in ongoing visits completed shown in Figure 6 may be explained by the reassignment of certain social workers. As further discussed in Chapter 3, the number of cases per social worker (caseload) decreased in 2009 for the service components typically requiring ongoing visits—family maintenance, family reunification, and permanent placement. Because social workers responsible for these components had to be redirected to address the backlog of investigations, caseloads in these service components increased in 2010.

In April 2009 Social Services advised all county CWS agencies that the majority of monthly ongoing visits should take place in children's residences. According to Social Services' regulations, the purpose of social worker visits is to verify the location of the child, monitor a child's safety, and gather information to assess the effectiveness of services provided. To best accomplish these objectives, a social worker should regularly visit a child in his or her home. The department's policy reiterates the importance of monthly in-home visits by stating that contact with the child outside of the home "should be the exception rather than the rule." However, our review of 30 cases showed that despite completing

⁷ *Child Welfare Services: California Can and Must Provide Better Protection and Support for Abused and Neglected Children* (2011-101.1).

case visits at least 90 percent of the time, social workers conducted visits at locations outside the home for three or more consecutive months in seven cases. In one of these cases, the social worker did not visit the child at her residence for nine months in a row. Instead, the social worker made consecutive monthly contacts at locations such as a department office, a courthouse, a school, or another public location. The department stated that, for a variety of reasons, including caregivers' work schedules, visiting children in their homes can be difficult. The department agreed that it will continue to emphasize the importance of visiting children in their homes during training sessions and during their supervisory reviews.

Recommendations

To ensure that child abuse and neglect allegations receive timely resolution, the department should do the following:

- Continue to monitor the status of its backlog of investigations but revise its policies and performance measures to no longer define the backlog as investigations over 60 days old. Rather, it should emphasize completing investigations within 30 days.
- Assess whether it needs to permanently allocate more resources to investigate allegations of child abuse and neglect.

To better ensure that inner-city regional offices are staffed by experienced social workers, the department should consider providing social workers with incentives to work in these areas or require them to remain in these offices for a period longer than the one year currently required.

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Chapter 2

THE DEPARTMENT FAILED TO PERFORM REQUIRED ASSESSMENTS BEFORE PLACING CHILDREN WITH RELATIVES

Chapter Summary

The Los Angeles County Department of Children and Family Services (department) did not consistently complete requisite assessments and background checks before placing children with relatives and extended-family members (placements with relatives). Based on our analysis of department data for 2008 through 2010, we found the department completed fewer than a third of required home and caregiver assessments prior to placing children with relatives. Further, after it later assessed and determined that the placements with a relative were either unsafe or inappropriate, the department often took more than a month to remove the children from these placements. In contrast, the department generally acted quickly to remove children from placements when an external party notified it of allegations. Nonetheless, after removing children from unsafe homes and investigating allegations of abuse or neglect (referrals), the department did not always notify appropriate oversight entities of the abuse or neglect. Finally, although not required by state law, the department has a robust review process that it implements for any child fatality that involves abuse or neglect.

Untimely Assessments and Background Checks Threaten Children's Safety

The department did not consistently perform important assessments and background checks before placing children in homes, as required by state law. Nine of the 20 placements with a relative that we reviewed occurred before the department completed required home and caregiver assessments.⁸ In addition, we found that in seven of these instances criminal background checks were not completed before placement. Departmentwide statistics further indicate that the department has placed numerous children with relatives prior to formally assessing and approving the homes and caregivers. Many of these placements did not end up passing one or more

⁸ As discussed in the Scope and Methodology section, the California Department of Social Services (Social Services) performs licensing activities, including background checks and home assessments, for foster homes in Los Angeles County. Therefore, we limited our review to the department's approvals for placements with relatives, which it is required to perform under state law. As shown in Appendix B, placements with relatives accounted for between 45 and 50 percent of all placements in Los Angeles County between 1999 and 2010.

Assessments That Must Be Completed Prior to Placement With Relatives

- **Caregiver assessment:** assesses whether the prospective caregiver is willing and able to care for the child.*
- **Home Assessment:** assesses whether the prospective home is in compliance with health and safety standards.*
- **Criminal history assessment:** assesses the criminal history of all adults (18 years of age and older) in the home or who have significant contact with the child by using the following:
 - The California Law Enforcement Telecommunications System
 - A criminal records check performed by the California Department of Justice (DOJ)
 - A federal criminal records check performed by the Federal Bureau of Investigation (FBI)[†]
- **Child abuse history assessment:** determines whether the prospective caregivers have a history of allegations of child abuse or neglect recorded in the Child Abuse Central Index.

Sources: California Health and Safety Code; California Welfare and Institutions Code.

* To ensure that counties follow the same standards in their relative placement approvals as used in the licensing of foster homes, the California Department of Social Services requires counties to use particular forms in completing home and caregiver assessments.

[†] If all other conditions for approval are met, state law allows the home to be approved prior to the receipt of the FBI criminal history check in certain instances. When individuals are fingerprinted for the DOJ and FBI checks, they must disclose, under penalty of perjury, any prior criminal convictions or any arrests for specified crimes.

of the assessments shown in the text box. When the caregivers or homes in which children had already been placed did not pass an assessment, the department took a comparatively long time to either remove children from the homes or complete reassessments and approvals. In addition to violating state law, placing children in unassessed homes exposes them to potentially dangerous people and environments. The department's lack of appropriate measures of compliance with assessment requirements has limited management's ability to identify and address this significant issue.

The Department Placed Children in Homes Before Performing Important Assessments and Background Checks

Prior to placing a child in a home, state law requires the department to assess whether prospective caregivers are willing and able to provide a child with needed support, and whether their homes meet certain health and safety standards. State law also requires relatives and extended-family members seeking placement of a child to go through certain background checks (see the text box). As shown in Figure 7, the department did not perform all necessary assessments and background checks for nine of the 20 placements with a relative that we reviewed.⁹ In these nine instances, the department did not assess and approve the home and caregiver before placing the child. Moreover, in seven of these instances, placements were made before the department performed all the necessary criminal history

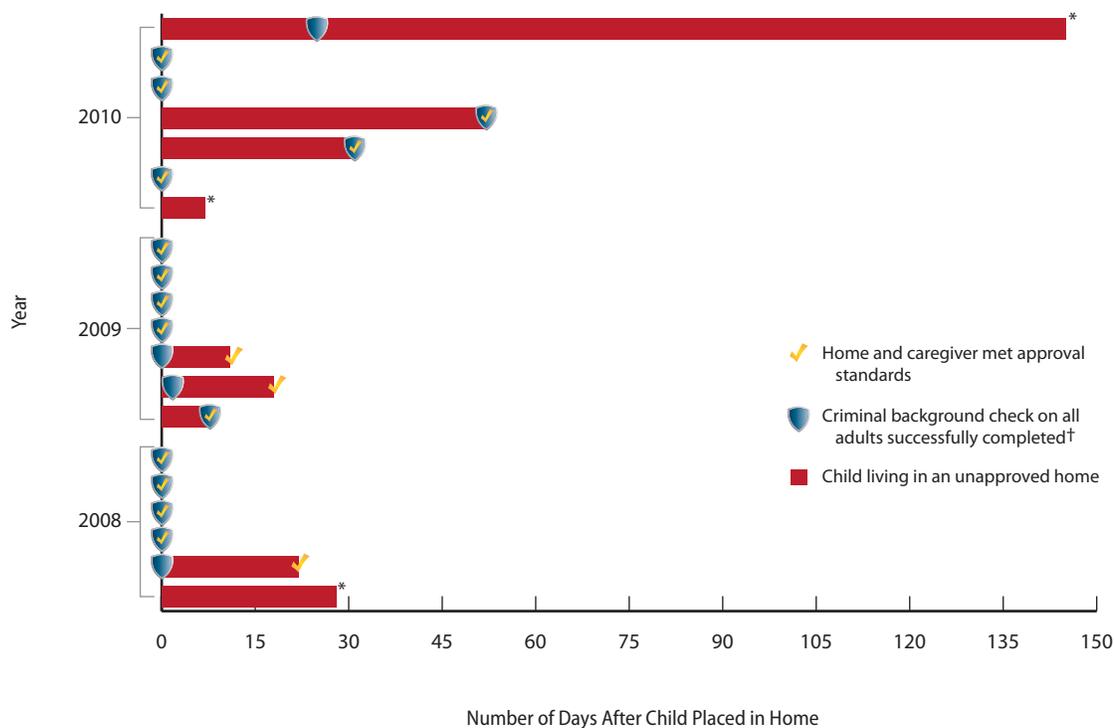
checks. In two of these placements, the child was removed from the home prior to the completion of the criminal history checks.

In one instance shown in Figure 7, in which a child was in an unapproved home for 145 days, the department's home assessment unit concluded on the day of placement that the home did not meet safety standards. The department recommended to a dependency court that the child not be placed in the relative's home, but the court did not agree and placed the child there anyway. Although the

⁹ Department policy requires social workers to initially assess homes and caregivers prior to placing children with relatives. However, the policy does not require social workers to document these assessments. Consequently, these initial assessments cannot be verified by us or department management. In our examination of relative placements, we determined whether the department completed and documented assessments using the forms required by Social Services.

court ordered the department to reassess the home to ensure that potential hazards were alleviated, the department failed to perform this reassessment. We also found that the department did not obtain self-disclosure statements about criminal history from relevant adults for eight of the 20 placements before placing children in these homes.

Figure 7
 Number of Days It Took the Department of Children and Family Services to Approve Homes for Selected Cases 2008 Through 2010



Source: California State Auditor’s analysis of 20 selected relative and extended-family-member placement cases obtained from the Los Angeles County Department of Children and Family Services.

* The child was removed from the home before all assessments and background checks were complete.

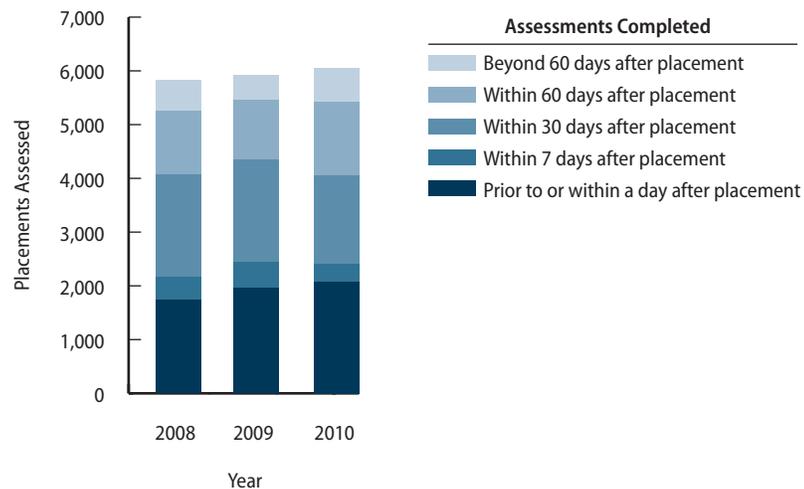
† For emergency placements, state law allows for an abbreviated background check, followed by a more thorough background check within a specified number of days. Our analysis above takes these provisions into account. Any background check symbol not at zero in the figure represents noncompliance with state law.

Because the department does not track whether it performed assessments and background checks prior to making placements with relatives, our office used the Child Welfare Services/Case Management System (CWS/CMS) to produce such an analysis. We compared the dates children were placed in the homes of relatives to the dates the department’s home assessment unit determined whether to approve or disapprove the homes and caregivers. Our analysis assumed that an assessment was timely if it was completed up to one day after the placement, although social workers should perform home and caregiver

assessments before placing a child in a relative's home. In our calculations, we allowed for an extra day to account for any minor processing delays. Our analysis also assumed that the date the social worker approved or disapproved the home was the date all requisite assessments were completed. We recognize that emergency placements can take place for which an abbreviated background check prior to placement is allowed. We also recognize that an actual placement can precede final approval, but our review of information in CWS/CMS found that only a small fraction of placements were identified as emergency placements.

As indicated in Figure 8, the department placed thousands of children with relatives before social workers determined whether the placements were safe and appropriate. Between 2008 and 2010, the department assessed fewer than a third of homes and caregivers before placing children with relatives. Very few additional assessments were completed within the first week of placement. Further, less than 67 percent of all assessments were completed within the first 30 days, which is the department's general policy, as we discuss in a later section of this chapter.¹⁰

Figure 8
Assessment of Homes and Caregivers for All Placements With Relatives in Los Angeles County 2008 Through 2010



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

Note: This figure excludes approximately 900 relative placements made between 2008 and 2010 that did not receive an assessment.

¹⁰ An official with Social Services explained that Social Services has not conducted oversight of relative approvals since 2008. Although its reviews related to federal funding eligibility touch on relative approval standards, the timeliness of assessments and background checks are not necessarily examined during these reviews. Consequently, any issues from 2008 forward regarding the timeliness of relative approvals in Los Angeles County would not have come to Social Services' attention under current monitoring mechanisms.

The Department's Delays Resulted in Children Living for Extended Periods in Potentially Unsafe Homes

The department's delay in assessing homes resulted in nearly 900 children living in homes of relatives that—once assessed by the department—were determined to be unsafe or inappropriate. Although this sum represents only 5 percent of all placements assessed by the department between 2008 and 2010, the children may not have been in these unacceptable homes if the department had performed its assessments and background checks prior to placement. Additionally, these children remained in unacceptable homes for extended periods. On average, they spent 54 days in these placements before the department completed assessments on the relatives and their homes. Also, the department took 43 days to either remove the children from the placements, or reassess and approve the homes and caregivers.¹¹ The deputy director who oversees the home assessment unit stated that social workers in the various regional offices are responsible for removing children from homes that do not pass an assessment. However, when a child is already placed with relatives, the court sometimes orders that the child remain with the relatives despite the home assessment unit's conclusion that the home does not meet standards. The deputy director added that the home assessment unit is not currently staffed at levels necessary to complete assessments prior to placement, which may also explain why we found that the department took so long to reassess homes that did not meet standards.

The department took 43 days to either remove 900 children from the placements, or reassess and approve the homes and caregivers.

The Department's Process for Approving Relatives Is Not Designed to Complete Assessments Before Placement

The department's process for formally assessing caregivers and homes is not designed to be completed prior to the placement of a child with a relative. Between 2008 and 2010, the department completed these assessments 21 days, on average, after the placement of children with relatives. Further, instead of monitoring whether it is assessing caregivers and homes and performing background checks prior to placement in accordance with state standards, the department monitors compliance with its internal policy. The department's policy allows social workers to place children after completing undocumented assessments of homes and caregivers,

¹¹ For this calculation, we used the median (middle number in a sequence of numbers) because some removals took a very long time, causing the average to be much higher at 73 days. Our analysis found 13 instances in which children were not removed from the home and the homes were not reassessed and approved. We referred these instances to the department for follow-up work, and the department researched the cases and found that most were due to specific court orders that the child remain in the relative's home, despite the homes or caregivers not meeting approval standards.

and allows the department's home assessment unit to complete formal caregiver and home assessments within 30 days, regardless of whether the child is already placed in the relative's home.

A deputy director who was previously in charge of the home assessment unit stated that she created the 30-day time frame as a goal four years ago because, at the time, the department was taking six to 12 months to complete each assessment. In most of these cases, the department placed the child in the relative's home several months before it completed the assessment. She stated that compliance with the 30-day goal went from 10 percent when it was first introduced to 98 percent at the end of her tenure. Although the department may have set a potentially reasonable goal four years ago to deal with the then-existing backlog, the goal has become a policy in the home assessment unit. This policy is reinforced by the department continuing to measure the unit's performance based on completions of home approvals within 30 days of an assessment request from a social worker, even if placement has already occurred. To make progress in ensuring that children are placed only in safe homes, the department needs to measure and monitor its performance relative to state law, which requires these assessments to take place before the placement.

The department's process for approving a relative's home can involve more than one person and take several days to complete. The social worker interested in placing a child with a relative is required to complete a request form and submit it directly to the home assessment unit in his or her office. However, the social worker frequently will submit a different form that contains only information on the placement to a clerical worker, who is responsible for entering the information into the placement database. Only after the information is entered into the database does the home assessment unit become aware of the placement and begin its assessment. According to a deputy director, it can take social workers several days after making a placement to complete this request form because they have numerous other duties competing for their time. The deputy director who oversees the home assessment unit stated that the unit is not currently designed and staffed to complete formal assessments prior to placement.

In our October 2011 report, we identified some best practices for placements.¹² For example, in Alameda County, social workers can use an assessment center where children may stay for up to 23 hours while staff gather information to make informed placement decisions. The department needs to consider what other county child welfare services (CWS) agencies are doing to comply with assessment requirements.

The department's process for approving a relative's home can involve more than one person and take several days to complete. Only after information is entered into the database does the home assessment unit become aware of some placements and begin its assessments.

¹² *Child Welfare Services: California Can and Must Provide Better Protection and Support for Abused and Neglected Children* (2011-101.1).

The Department's Investigation of Sex Offender Addresses Matching Child Placement Addresses Highlights a Potential Weakness in Background Checks

Responding to a directive from Social Services in August 2011, the department investigated numerous referrals in which registered sex offenders' addresses matched addresses of children in the CWS system. Although the department found that the majority of the sex offenders were not residing at the identified addresses, investigations showed that the State could better ensure that sex offenders are not living among children in the CWS system. In our October 2011 report, we described how we compared addresses in the California Department of Justice's (DOJ) sex offender registry to addresses in the licensing and case management systems managed by Social Services. We provided 1,062 address matches to Social Services and asked it to follow up to determine whether children or other vulnerable populations were at risk and to ensure that appropriate action occurred. Based on information provided by Social Services, over 300 address matches related to Los Angeles County. Social Services asked the department to investigate and report back on 126 of these address matches. Social Services' community care licensing division (licensing division) performed follow-up activities on the remaining address matches in Los Angeles County that were associated with state-licensed facilities.

According to a summary provided by Social Services, the department found that in 108 instances the sex offender was not living at the registered address.¹³ As stated in Table 3 on the following page, for the remaining 18 address matches, there were six instances in which the department found that the sex offender had some association with, but did not reside in, the home. In three instances, the sex offender lived in the home, but no children in the CWS system were found to be currently living there. The final nine instances are described in the table.

We examined 22 of the 126 address matches the department investigated, including all instances in which a sex offender was found residing in a home with a child in the CWS system. Even when a sex offender was found not to be living in a home, social workers sometimes became aware of where the sex offender did live and did not close their investigation until they confirmed that the sex offender registered at the correct address. We commend the department's social workers for taking this extra step to

Even when a sex offender was found not to be living in a home, social workers sometimes became aware of where the sex offender did live and did not close their investigation until they confirmed that the sex offender registered at the correct address.

¹³ We attempted to verify the accuracy of Social Services' summary of follow-up actions for 22 selected address matches. In a few instances, we were able to find more up-to-date information than what was included in the department's investigative summaries. In one instance, we found the summary to be materially inaccurate, failing to mention that the child was removed from the home of a registered sex offender and from the care of the guardian who allowed the child to be in the home. In this instance, we traced the incorrect information to an error in information the department previously sent to Social Services.

ensure compliance with laws designed to protect the public. In one instance, the sex offender was found to be living not in the home but near the property of a child in a CWS placement. In this instance, social workers investigating the potential address match were able to raise awareness with the child's family about the potential threats to the child's safety.

Table 3
Results of Follow-Up on Sex Offender Address Matches

| RESULT OF FOLLOW-UP ON ADDRESS MATCH | COUNT OF INSTANCES |
|--|--------------------|
| Sex offender was not living at the registered address | 108 |
| Sex offender had some association with, but did not reside in, the homes where children resided | 6 |
| Sex offender lived at the address, but no children in the child welfare services (CWS) system were present | 3 |
| Sex offender was present in the home (or on the property in an adjacent or attached structure), but the Los Angeles County Department of Children and Family Services (department) determined that the children were not at risk and did not remove them | 3 |
| Sex offender was present in the home, but CWS children aged out of the system or moved during or prior to the investigation | 3 |
| Sex offenders were removed from the residences of children in a CWS placement | 2 |
| Children were removed from the home and removed from the care of the guardian who allowed the children to reside in the home of a sex offender | 1 |
| Total | 126 |

Source: California State Auditor's analysis of California Department of Social Services' summary of follow-up on sex offender address matches related to the department.

In each instance in which a sex offender was residing in a home, we found no indication that the department knew that a sex offender was present. For example, in the instance referred to in Table 3 in which children were removed from a sex offender's home and taken away from a guardian, the guardian had lied to the social worker about the presence of the sex offender. Similarly, the sex offender, who in the past had been convicted of three counts of lewd acts with a minor under 14, lied to law enforcement about the presence of children in the home. The social worker made regular visits to the home (some unannounced) but never became aware that the sex offender was living there. The sex offender was either not disclosed or not living in the home at the time the home was approved for placement; therefore, no background checks were performed on him. Only when the social worker—prompted by a referral from Social Services—called and compared information with the county sheriff's office was the deceit discovered. The department subsequently discovered that the sex offender had lived there for one year while children were present. Although the children

stated that the sex offender never abused them, the department substantiated neglect on the part of the caregiver and removed the children from her care.

As indicated in our October 2011 report, currently there is no general prohibition against registered sex offenders residing with children in the CWS system. Removing children from a CWS placement or licensed facility, or directing the sex offender to leave the home, are the only potential consequences in such cases. As amended in January 2012, Assembly Bill 493 (AB 493), if enacted, would create a general prohibition against registered sex offenders living or working in licensed child facilities or CWS placements and would impose criminal consequences on sex offenders found to be in violation of this prohibition.

AB 493 would allow a registered sex offender to live with a child in the CWS system only if the prohibition is waived by a court because the offender is a parent, relative, or extended-family member and the placement of the child in the residence is in the child's best interest. Social Services stated that in certain circumstances counties do not have an obligation under current regulations or policies to remove children from homes due to the presence of a registered sex offender, but counties are still required to determine the immediate risk and take appropriate steps to ensure the safety of children in these instances.

As indicated in Table 3, the department decided in three instances to allow the children to remain in the home (or on the same property in two cases) of a registered sex offender. These three instances involved a registered sex offender living in a separate structure where he has no interactions with members of the household, an older registered sex offender with numerous health problems living in a trailer adjacent to the home, and a father (who is a registered sex offender) living in the same home as his 18-year-old son, who, although still in the CWS system, asserted that he is capable of protecting himself. While these and other factors informed the department's judgment, it is not clear that the department complied with requirements related to criminal background checks in all three of these instances. AB 493, if enacted, would clarify that circumstances like those above involving CWS children (who generally are dependents of the court) should be brought before the court for resolution.

The Department Generally Acted Quickly to Remove Children From Placements Upon Receiving a Complaint but Often Did Not Notify Oversight Entities of Abuse and Neglect

Of the 20 cases we reviewed in which abuse or neglect was alleged, the department acted swiftly in 19 cases to remove the children from the placement homes until social workers could determine

Currently there is no general prohibition against registered sex offenders residing with children in the CWS system.

Although the department generally removed children quickly, it did not always notify the appropriate oversight entities of abuse or neglect allegations. Of the eight cases we reviewed that required such a report to DOJ, the department submitted only three.

whether the placements were safe and appropriate. In the other case, the department could have acted more promptly. The child in this case, as well as older children living in the home, told social workers several times over a nine-month period that a particular adult, who had a criminal history that included domestic violence, was living in the home, even showing a social worker his clothes on one occasion. However, social workers delayed acting on this information because of the caregiver's denials. Even after the caregiver admitted that the adult was living there, social workers allowed the caregiver another chance to remove this individual. Despite repeated evidence that the individual was living in the home, the department did not remove the child in this case until it received an allegation that this individual physically abused the child.¹⁴ The department agrees that this child should have been removed much earlier. It stated that this case is an exception and that department policy strongly supports social workers removing children from placements whenever inappropriate risk exists.

Although the department generally removed children quickly, it did not always notify the appropriate oversight entities of abuse or neglect allegations. Until recently, the department was required to notify DOJ of all alleged abuse when a social worker determines that allegations of physical abuse are either substantiated or inconclusive.¹⁵ Of the eight cases we reviewed that required such a report to DOJ, the department submitted only three. In one of the five unreported cases, the department removed a child from the care of a relative due to a substantiated allegation of physical abuse, but it subsequently placed the child back in the home with the same relative. If substantiated child abuse allegations are not reported to DOJ, social workers making subsequent placements will not benefit from having complete DOJ background reports.

The department is also required to immediately report any alleged child abuse or neglect that occurs in a licensed facility to Social Services' licensing division. The licensing division uses this information to help prevent it and counties from licensing or certifying such homes to care for children. The department reported six of the seven relevant cases to the licensing division. The department stated that instances in which the allegations are not reported to DOJ or the licensing division can be attributed to a gap in either supervisor oversight or the training of the social worker who processed the allegation.

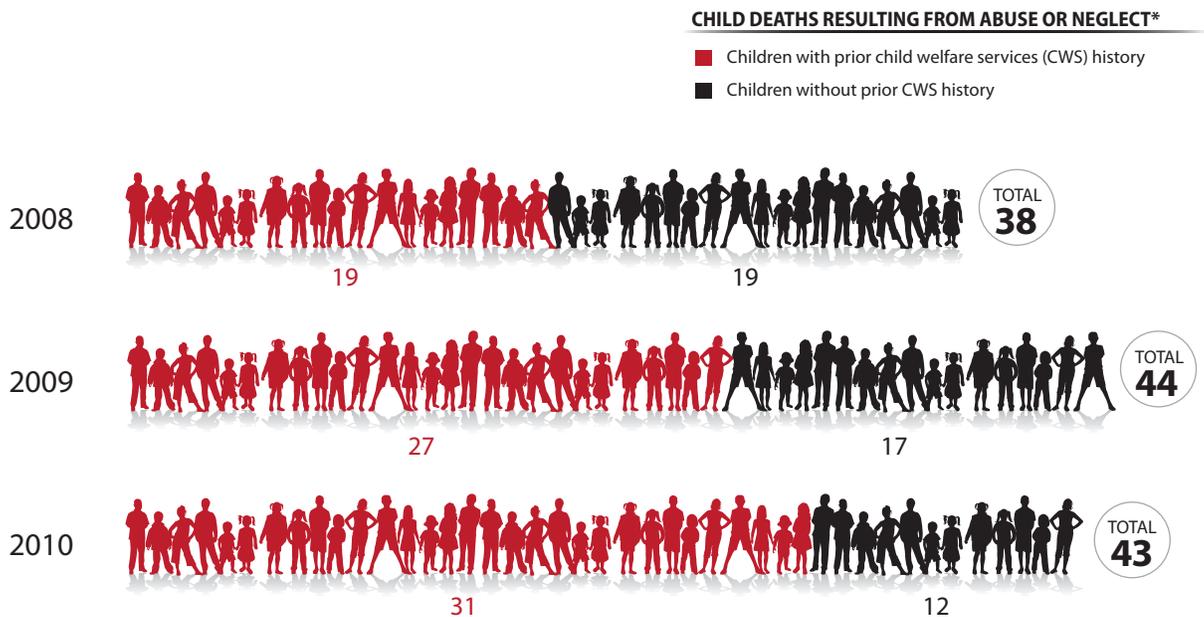
¹⁴ The department removed two other minors living in the home prior to this incident.

¹⁵ Effective January 1, 2012, social workers are no longer required to notify DOJ of referrals they investigate where evidence of child abuse or severe neglect is determined to be inconclusive.

The Department Has an Extensive Child Death Review Process

The department has an extensive process for reviewing child deaths that it uses to prepare for litigation and to deal with personnel issues. It also uses its death review process to identify weaknesses and make recommendations to improve its policies and practices. As shown in Figure 9, Los Angeles County has had numerous child deaths due to abuse or neglect in the three years represented, and many of these children had prior history with CWS.¹⁶

Figure 9
 Child Deaths in Los Angeles County Resulting From Abuse or Neglect
 2008 Through 2010



Source: Report from the Los Angeles County Department of Children and Family Services (department) dated October 2011.

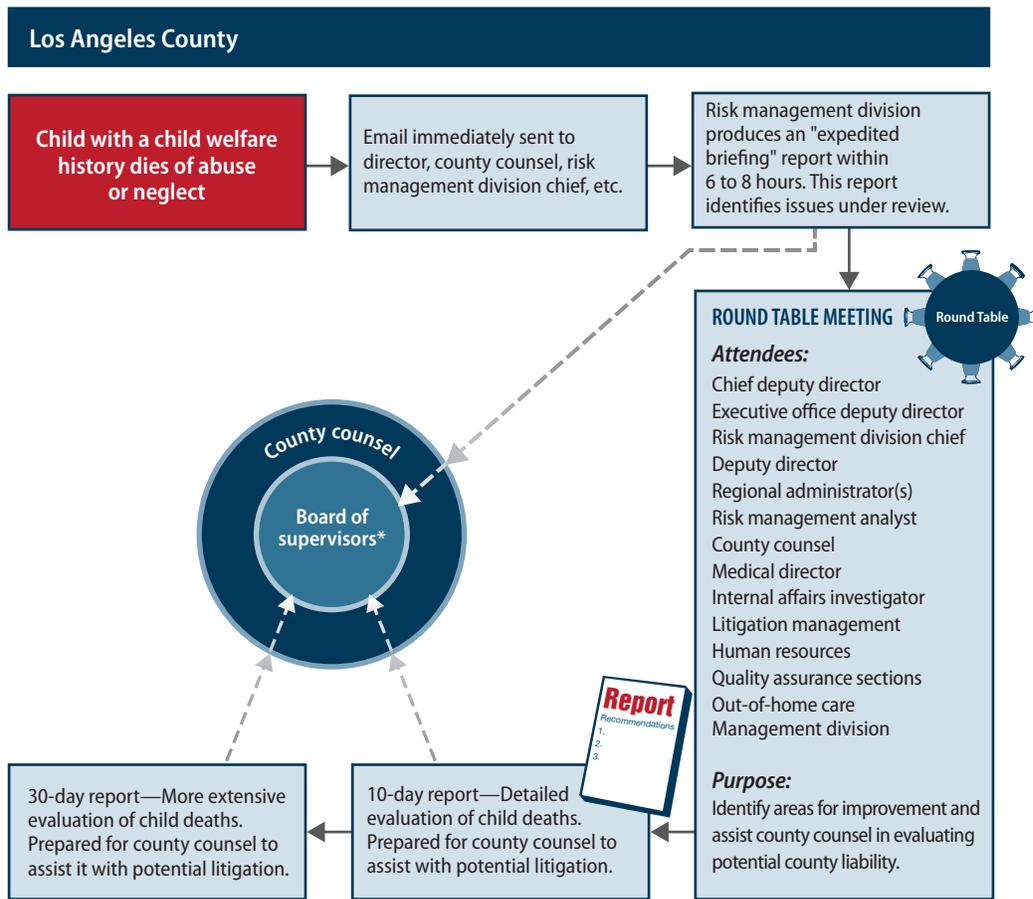
* Determinations of whether children died of abuse or neglect and determinations of whether children had CWS history were made by the department.

As shown in Figure 10 on the following page, the department’s process for reviewing child deaths involves an expedited briefing report, administrative round table meeting, follow-up report with updated information (10-day report), and comprehensive final

¹⁶ Appendix C provides additional information, including demographic details, on child deaths in Los Angeles County. Data from 2011 is not shown in the figure because determinations of whether a child died of abuse or neglect can take many months. Sufficiently accurate numbers for 2011 will not be available until after the publication of this audit report.

30-day report. For the 25 child death cases that we reviewed, the department completed some combination of expedited, follow-up, and comprehensive reports for all 25 cases.

Figure 10
The Los Angeles County Department of Children and Family Services’ Child Death Review Process



Source: Los Angeles County Department of Children and Family Services’ personnel, policies, and procedures.

Note: This figure describes the general death review process during the audit. In some instances, interim reports may be made before the 10-day report is generated. Similarly, follow-up reports may be made after the 30-day report.

* The board of supervisors can request independent legal reviews of child deaths by the county’s children’s special investigations unit. Between December 2009 and September 2011 this unit produced 10 detailed reports on individual child fatalities and two reports summarizing multiple child deaths.

For the 25 child deaths that we reviewed, the department or county council made several recommendations for improvement. Of the five recommendations that we reviewed, the department implemented three. One of the three implemented recommendations was to review and strengthen the department’s policy regarding assessing newborns in families with open cases. The death that prompted this recommendation involved an infant the department

left with its mother despite the mother having extensive CWS history involving the loss of custody of her other children and not being allowed to have unmonitored visits with them. The new policy highlights the importance of social workers considering the status of siblings when deciding on the safety of a newborn infant.

In another death review, the department recommended escalating the level of review for cases with extended histories of recurring issues—for example, drugs, domestic violence, or dirty and unsafe homes—prior to closing the referral. This recommendation resulted from a case in which social workers, during multiple investigations, incorrectly concluded that the factors observed did not warrant creating a CWS case. The recommendation resulted in a new policy requiring social workers to obtain the approval of assistant regional administrators before closing referrals regarding a caregiver with extensive referral history.

The department did not implement two recommendations because it believed the recommendations were unnecessary. For example, one recommendation stated that supervisors need to reinforce the department's policy stipulating that social workers are required to maintain regular contact with each other when they are assigned to related cases. The department stated that it does not believe it needs to implement this recommendation because situations involving two social workers assigned to a case are limited and it already has several policies that instruct social workers to communicate with each other. Nonetheless, it appears that these other policies were ineffective in the case prompting the recommendation. The other unimplemented recommendation stated that the department's policy regarding the transfer of referrals from the after-hours county hotline office to regional offices should be reviewed and strengthened. When asked to provide the policy revision that resulted from this recommendation, the department pointed us to a policy revision that was made prior to the child's death and thus was not made in response to the recommendation. Social workers and the children to whom they provide service could benefit from the department implementing these two recommendations, because they could help ensure that child safety needs are being met.

Recommendations

To ensure that it is placing children only in safe homes, the department should measure its performance and adjust its practices to adhere to state law, which requires that all homes be assessed prior to the placement of the child.

To improve its process for placing children with a relative, the department should analyze the best practices used by other county CWS agencies for such placements. The department should then implement changes in its practices so that relatives and their homes are approved prior to placement, as required by state law.

To ensure that social workers have as much relevant information as possible when placing children and licensing homes, the department should report requisite allegations of abuse or neglect to DOJ and Social Services' licensing division.

To fully benefit from its death review process, the department should implement the resulting recommendations.

Chapter 3

HIGH TURNOVER IN KEY MANAGEMENT POSITIONS HAS HAMPERED IMPROVEMENT EFFORTS

Chapter Summary

For over a year, the Los Angeles County Department of Children and Family Services (department) has had instability in its director position. Numerous changes in the director position, as well as in other key management positions, led to turnover rates in top management that exceeded overall department and national turnover averages. As a result of turnover in the director position, a strategic plan that was nearly complete was halted and replaced with a new strategic planning process a year later. These sudden management changes, as well as numerous policy shifts, contributed to a general sense of instability within the department that has hampered its efforts to make long-term improvements in its protection of children.

Instability in Key Management Positions Raised Uncertainty Among Staff and Put Strategic Planning Efforts on Hold

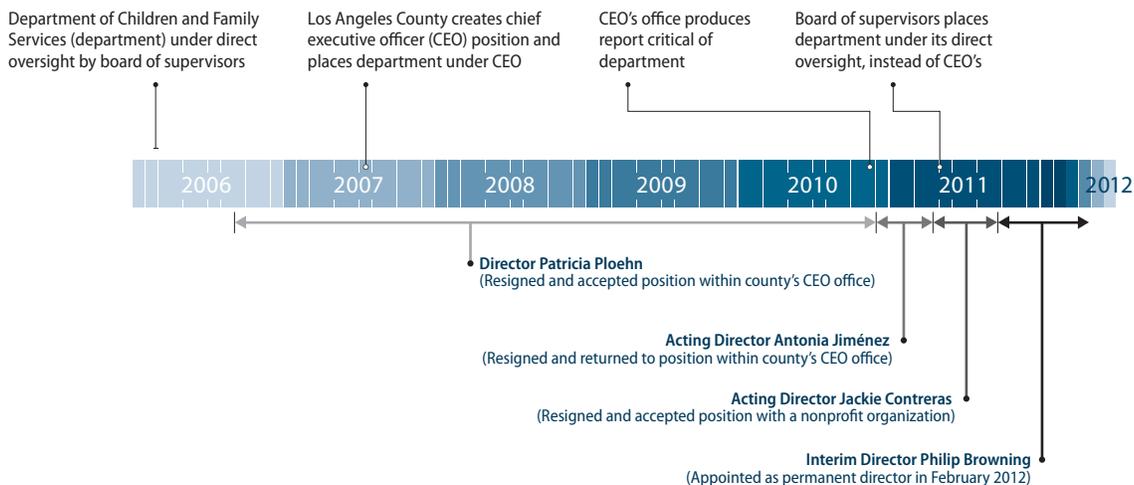
The department's high turnover in key positions has hindered its efforts to address the challenges it has faced. Specifically, turnover in its director position impeded the department's ability to develop and implement a strategic plan that would provide cohesiveness to its various initiatives and communicate a clear vision to department staff and external stakeholders. Further, management and staff indicated that this turnover, as well as the controversies surrounding the departure of former directors, caused fear and mistrust to permeate the department, which in turn caused hesitancy in organizational and case-specific decision making.

As a recipient of federal funds, the department is required to maintain processes to ensure compliance with applicable laws and requirements (internal controls). Our standards require us to examine the department's internal controls, including a review of whether management and employees have established a positive and supportive attitude toward internal controls (control environment). One factor contributing to a positive control environment is the absence of excessive turnover among a department's key personnel. Between 2006 and 2011, turnover among the department's executive management team averaged 25 percent (ranging from a high of 45 percent in 2011 to a low of 10 percent in 2007). The Bureau

of Labor Statistics published data indicating that, over the same time period, the average turnover among state and local government employees was roughly 16 percent.

The executive management position with the most turnover was the director's position. Over the past year and a half, the department has had four directors. As shown in Figure 11, three of the four directors have been acting or interim directors, functioning as director while the board of supervisors deliberated over its selection of a permanent director. In February 2012 the board of supervisors appointed the then interim director to the position on a permanent basis. The figure also shows other key events relevant to the county's oversight of the department.

Figure 11
Time Line for the Los Angeles County Department of Children and Family Services



Sources: Los Angeles County board of supervisors' Web site, Los Angeles County CEO's Web site, and documents provided by the department's human resources unit.

The recent turnover in directors began in December 2010 with the resignation of the previous permanent director. According to that former director, the department and eventually her directorship came under scrutiny beginning in 2009 because of increased media coverage of individual child deaths. To relieve some of the constant pressure from negative media reports, and to restore the support that the department needed to be effective, she resigned as director. She believed her resignation would quiet media criticisms and allow the department to once again focus on steady, systematic improvements instead of being reactive to such intense scrutiny.

In 1998 an external management audit stated that the department faced a bewildering number of external demands and that it was under pressure to adopt ideas posed by advisory bodies. The audit concluded that the department may too quickly commit to new ideas before thoroughly vetting them. This pattern revealed itself when the department implemented policies that contributed to the creation of a large backlog in uncompleted investigations, as discussed in Chapter 1. This backlog, in turn, contributed to increased pressure on the department, which resulted in the resignation of the former director.

Her resignation was followed by three temporary directors, the last of which was only recently made a permanent director. We interviewed the four directors, who agreed that functioning as director of this department is uniquely challenging because of the amount of scrutiny from the media and board of supervisors (as seen in the text box). Two of the directors indicated that the director and department need the support of the board of supervisors and other county departments to be effective in their efforts to protect children.

Turnover in the director position led to uncertainty about the direction of the department and its priorities. The department's medical director—who is the longest-tenured member of the department's executive team—stated that he has seen the department move from stable, generally effective leadership coming from the director position to a situation in which the director's position became highly unstable and therefore less effective.

He added that the lack of a permanent director for over a year paralyzed some reform efforts and contributed to an increase in fear and mistrust among department employees. A former director commented that the numerous changes in interim and acting directors would naturally cause some uncertainty among staff because each new director has his or her own set of priorities and directives. She further stated that with no permanency in the director position, some management efforts—the strategic plan specifically—may have become stalled.

Prior to the previous permanent director's resignation in December 2010, the department had spent significant time and resources developing a strategic plan. When she resigned, the strategic plan was placed on hold. The first temporary director to follow focused her attention on implementing recommendations from a November 2010 report from the county's chief executive office, which she wrote prior to becoming the acting director.

Difficulties Faced by Directors

Being the director of the Los Angeles County Department of Children and Family Services "is a challenging position because the director is under the microscope [24 hours a day, seven days a week], meaning the media, the five board member offices, the employee union, and other community or provider groups are scrutinizing management actions. Part of this scrutiny comes from the fact that any department errors—either in going too far to protect children or in not going far enough—can have dire consequences. Any child deaths, especially those in which the department may have been able to do more, weigh heavily on the department internally but also cause a storm of increased scrutiny. This environment can make it difficult for even the best managers to direct the department."

Source: Antonia Jiménez, former acting director.

In addition to turnover in the director position, the department experienced a number of departures in other key management positions, including the chief deputy, senior deputy, and other deputy director positions.

The current director has revived efforts to complete the strategic plan. He believes the plan is important because it will be the department's guide for the next four years in charting its direction and priorities. The plan also will bring together in one cohesive document the various reforms currently underway at the department. According to the current director, a draft of the strategic plan should be available in April 2012. He plans to share the draft with the board of supervisors, the superior court, Social Services, and other advocates and community partners.

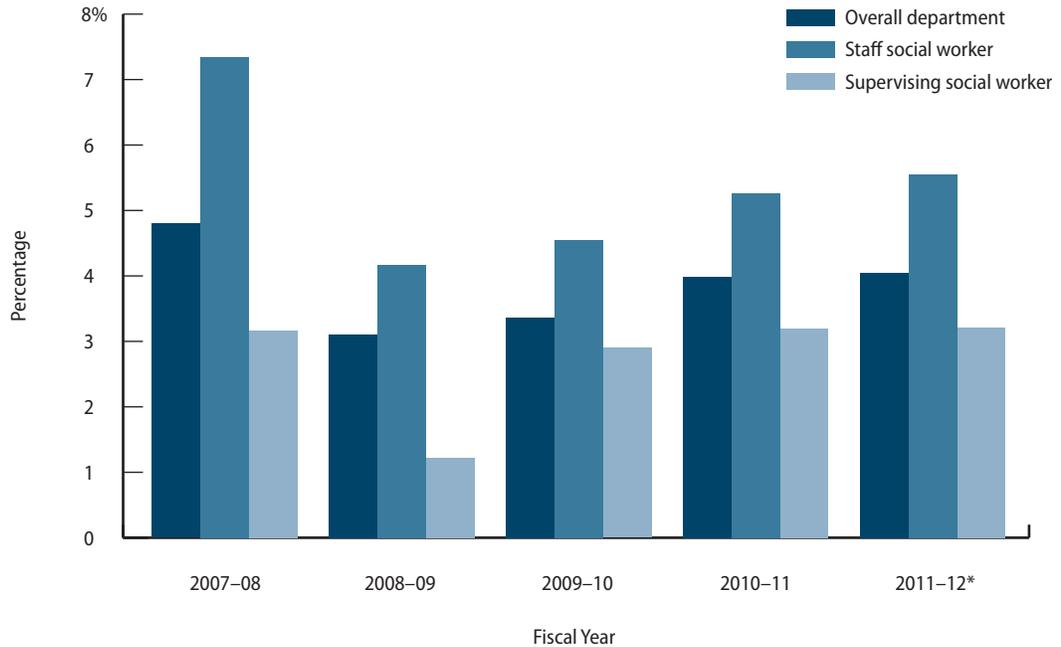
In addition to turnover in the director position, the department experienced a number of departures in other key management positions, including the chief deputy, senior deputy, and other deputy director positions. The department has been without a chief deputy director since April 2011, when the former chief deputy director became the interim director. The 1998 external management audit of the department emphasized the importance of having a chief deputy director focused on internal management so that the director can focus on external communications and strategy. Additionally, three of the department's six deputy directors were acting deputy directors as of February 2012. The new director explained that the chief deputy and senior deputy director positions have remained open because, as the interim director, he wanted to afford whoever was appointed as the new permanent director the opportunity to select the individuals for these key positions. Now that he has been appointed director, he is focusing on filling these positions.

Overall, the Department Has Had Relatively Low Turnover Rates

In contrast to its top management positions, the department as a whole has had relatively little turnover. As indicated earlier, the annual turnover rate for its key management positions averaged 25 percent over the last five years. Over the same period, the annual turnover rate for state and local government employees nationwide averaged roughly 16 percent. However, as shown in Figure 12, the department's turnover rates overall and among its social workers were much lower, indicating a greater level of stability.

Staff social workers and supervising social workers are key positions necessary to ensure that important services are provided to children and families in Los Angeles County. Staff social workers—who make up 44 percent of the department's budgeted positions—are the front line of the department; they knock on doors to investigate allegations of abuse and neglect, provide ongoing services to children and families, and place children in foster homes. Supervising social workers—representing 9 percent of the department's budgeted positions—provide oversight and counsel to staff social workers.

Figure 12
Turnover Rates at the Department of Children and Family Services
Fiscal Years 2007–08 Through 2011–12



Source: Unaudited October 2011 report from the Los Angeles County Department of Children and Family Services’ human resources unit.
 * Turnover rates for fiscal year 2011–12 are projected based on results from July 2011 through October 2011.

The results from our employee survey—available in Appendix D—provide some insight into why the department has a relatively stable workforce. Employees generally indicated that they are accountable for defined, measurable tasks and objectives. They indicated that they have sufficient information to do their jobs and receive adequate supervision. Department employees typically believe that employees in their work units are treated fairly and justly. Even so, survey responses and other interviews indicate that the department, with approximately 7,000 employees, has problems localized in certain regions or work units. As mentioned in Chapter 1, turnover in inner-city regions (Compton, for example) is a continual concern and has had an effect on the backlog of uncompleted investigations. As indicated in Appendix D, employees in Compton pointed to turnover as a major problem affecting their jobs. In fact, the average response from Compton employees to the question related to turnover resulted in the lowest, and thus the worst, score among the responding regional offices. Survey comments also indicated that in some regions and work units employees do not feel that members of management listen to them, respond appropriately to honest feedback, or treat each employee fairly. We provided aggregate survey results, by region, to department management for further discussion and follow-up.

Efforts to Decrease Emergency Response Caseloads Increased Caseloads for Social Workers Handling Ongoing Cases

The caseloads for social workers who investigate referrals (emergency response) increased dramatically beginning in 2009. By redirecting other workers to aid in emergency response, the department erased improvements it had made in the caseloads for social workers involved in family maintenance, family reunification, and permanent planning. Caseloads for these service components—some of which had begun to approach recommended levels—are now all higher than some recommended standards. 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 evaluating the adequacy of the child welfare services (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 CWS system since the creation of the 1984 budgeting standards. Published in April 2000, the SB 2030 study recommended two sets of caseload standards—maximum and optimal. As shown in Table 4, the caseloads in both standards are lower than the ones outlined in the 1984 agreement.

Table 4
Comparison of Caseload Standards

| SERVICE COMPONENT | 1984 AGREEMENT | SENATE BILL 2030 STUDY | | DEPARTMENT LABOR AGREEMENT | |
|----------------------|--------------------------------------|------------------------|------------------|----------------------------|-----------------|
| | STANDARD USED FOR BUDGETING PURPOSES | MAXIMUM CASELOAD | OPTIMAL CASELOAD | CASELOAD TARGET* | CASELOAD LIMIT* |
| Hotline | 322.50 | 116.10 | 68.70 | NA [†] | NA [†] |
| Emergency response | 15.80 | 13.03 | 9.88 | 27 [‡] | 33 [‡] |
| Family maintenance | 34.97 | 14.18 | 10.15 | 31 [§] | 38 [§] |
| Family reunification | 27.00 | 15.58 | 11.94 | | |
| Permanent placement | 54.00 | 23.69 | 16.42 | | |

Sources: An April 2000 study published in response to Senate Bill 2030, Statutes of 1998, and the Los Angeles County Department of Children and Family Services' (department) labor agreement.

NA = Not applicable.

* The labor agreement sets caseload targets and limits for trainees at 75 percent of those shown in the table.

[†] No caseload target or limit exists for the hotline in the labor agreement.

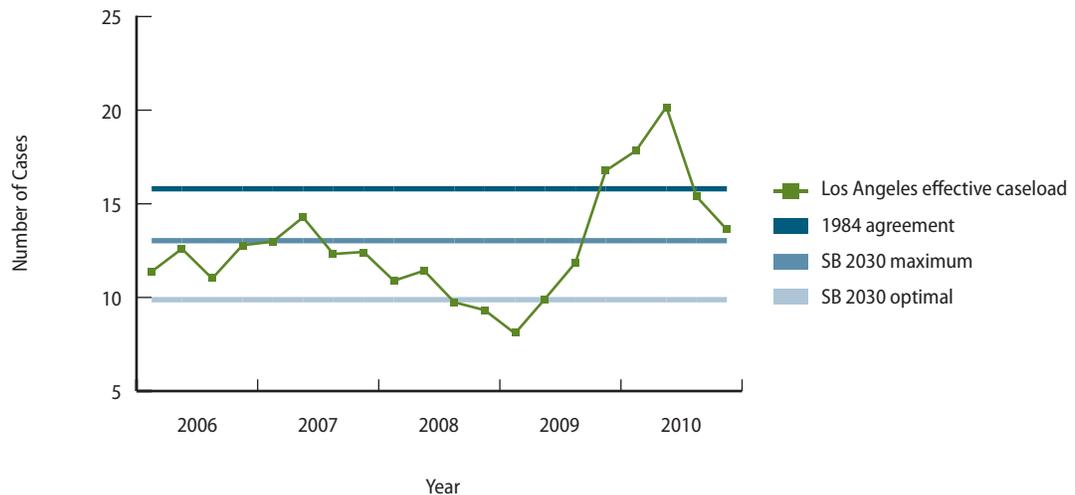
[‡] A department official explained that the department's target and limit for emergency response are higher than the other caseload standards in the table because the labor agreement is on a per child basis. The other standards in the table are based on number of referrals, which can include multiple children.

[§] The labor agreement combined caseload targets and limits for family maintenance, family reunification, and permanent placement.

Based on its agreement with the labor organization that represents the county's social workers, the department has devised its own methodology and standards against which it compares actual worker caseloads. A deputy director explained that supervisors and regional administrators monitor the caseloads of workers against these targets and limits to ensure that the department abides by the labor contract and that social workers have manageable workloads to provide the necessary services to children and their families.

Referral investigations per worker, also termed emergency response caseloads, exceeded recommended and even budgetary standards for a time. As shown in Figure 13, emergency response caseloads, which generally declined from 2007 through the beginning of 2009, increased dramatically from 2009 through the middle of 2010. This pattern coincided with the backlog of uncompleted investigations described in Chapter 1. Emergency response caseloads then decreased through the latter half of 2010, likely due to the management actions described in Chapter 1. Between 2007 and 2010, hotline calls per worker grew by almost 7 percent.

Figure 13
Emergency Response Investigations Per Worker in Los Angeles County
2006 Through 2010

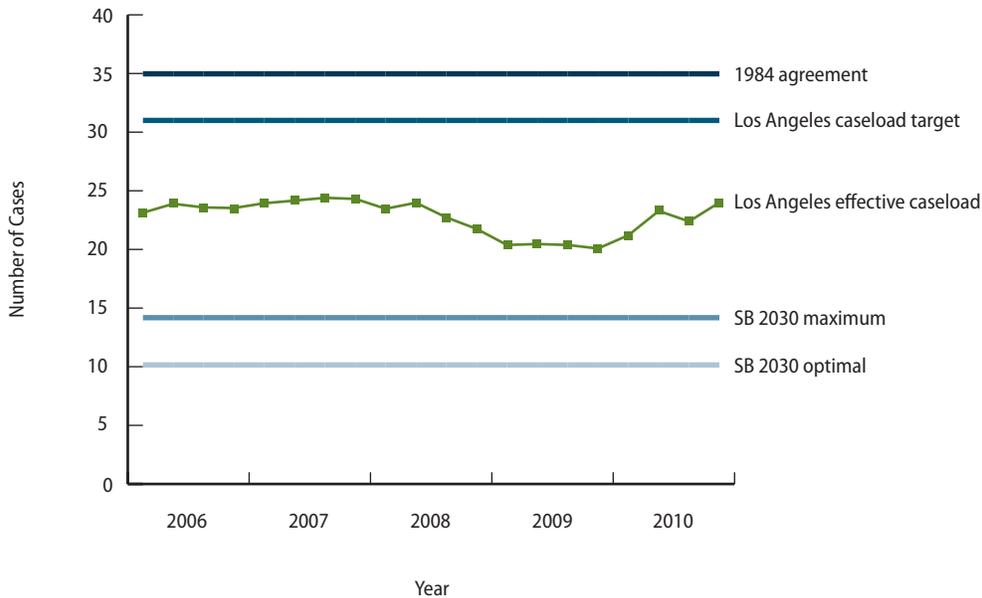


Source: California State Auditor's analysis of data obtained from the California Department of Social Services' Child Welfare Services/Case Management System.

Note: The caseloads shown above exclude clerks, interns, supervisors, and others who may have been assigned a case for some period of time but are not regular, caseload-carrying social workers. We do not include a labor agreement target in this figure because, as noted in Table 4, the Los Angeles County Department of Children and Family Services target is on a per child basis. The caseload standards in the figure, as well as our calculations of referral investigations per worker (emergency response caseloads), is based on the number of referrals.

The actual caseloads for the three service components generally involved in ongoing case management—family maintenance, family reunification, and permanent placement—each hovered between the department’s caseload targets and the caseload maximum suggested by the SB 2030 study. As shown in Figure 14, caseloads in family maintenance decreased in 2008, remained stable in 2009, and returned to higher levels in 2010.

Figure 14
Family Maintenance Caseloads in Los Angeles County
 2006 Through 2010

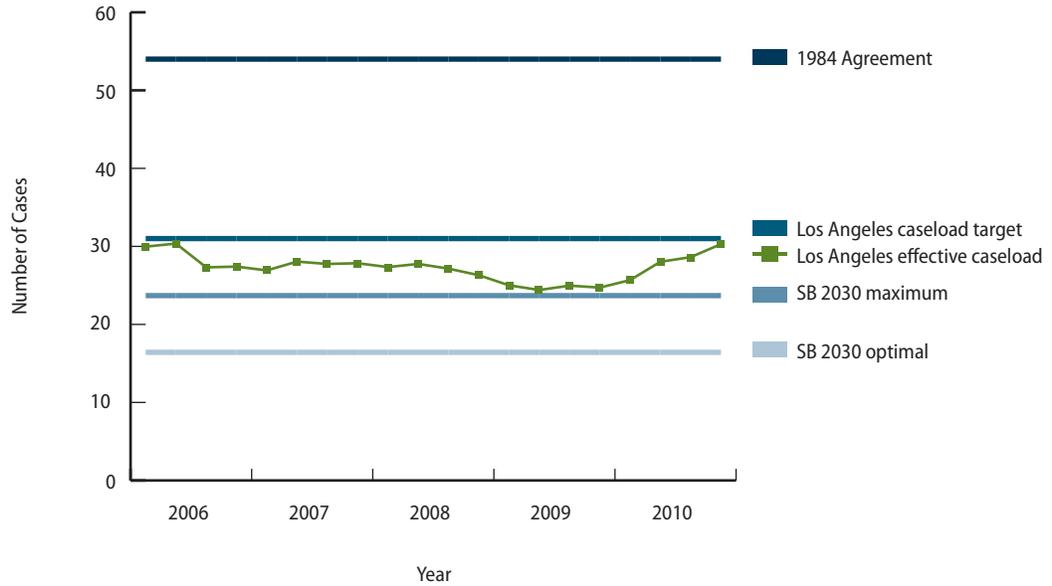


Source: California State Auditor’s analysis of data obtained from the California Department of Social Services’ Child Welfare Services/Case Management System.

Note: The caseload numbers shown above exclude clerks, interns, supervisors, and others who may have been assigned a case for some period of time but are not regular, caseload-carrying social workers.

As shown in Figure 15, caseloads in permanent placements followed a similar pattern, decreasing in 2008, remaining stable at around the SB 2030 maximum in 2009, and returning to higher levels in 2010. Family reunification, which is not shown in a figure, followed a similar pattern. According to a former director of the department, these caseload increases occurred when the department redirected its resources to aid in reducing the backlog of emergency response investigations.

Figure 15
Permanent Placement Caseloads in Los Angeles County
2006 Through 2010



Source: California State Auditor’s analysis of data obtained from the California Department of Social Services’ Child Welfare Services/Case Management System.

Note: The caseload numbers shown above exclude clerks, interns, supervisors, and others who may have been assigned a case for some period of time but are not regular, caseload-carrying social workers.

Recommendations

To provide effective leadership, the director should form a stable executive team by filling the department’s chief deputy director, senior deputy director, and other deputy director positions.

To create and communicate its philosophy and plans, the department should complete and implement its strategic plan.

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: March 29, 2012

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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

INFORMATION ON REPORTS OF ABUSE AND NEGLECT IN LOS ANGELES COUNTY

The Joint Legislative Audit Committee directed the California State Auditor to provide, for the last three years available, the number of abuse and neglect allegations and the disposition of these allegations. Table A presents this information for the Los Angeles County Department of Children and Family Services (department) for the years 2006 through 2010. Table A shows that the number of allegations evaluated out (not investigated) increased significantly between 2008 and 2009. Between 2006 and 2008, the rate of allegations evaluated out ranged between 8.1 and 8.6 percent. In contrast, in 2009 and 2010 the rate ranged between 11.6 and 11.9 percent. The regional administrator for the child abuse hotline stated that in January and February of 2009, the department provided training to all hotline supervisors on the tools used in the referral assessment process. The regional administrator also stated that the hotline's management team instructed supervisors to review a greater percentage of incoming referrals to ensure that the department is using its resources efficiently by investigating only referrals that allege abuse or neglect. The department believes this training and the strategy of having hotline supervisors review more referrals have improved the quality of the referrals investigated and helped the department to more efficiently use its resources.

Table A

Total Number and Disposition of Referrals for the Los Angeles County Department of Children and Family Services

| 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 |
|--------------------------|---------------------|------------------------|---------------------------|--------------------------|-----------------------|----------------------------|---|
| 2006 | 78,891 | 244,976 | 42,564 | 38,820 | 142,500 | 21,077 | 15 |
| 2007 | 80,780 | 260,981 | 44,540 | 38,932 | 156,280 | 21,225 | 4 |
| 2008 | 80,681 | 263,820 | 44,004 | 36,660 | 160,596 | 22,553 | 7 |
| 2009 | 77,945 | 247,275 | 46,793 | 48,057 | 123,657 | 28,734 | 34 |
| 2010 | 84,790 | 275,491 | 50,538 | 50,298 | 133,641 | 32,732 | 8,282‡ |

Source: California State Auditor's analysis of data, as of March 2, 2011, obtained from the California Department of Social Services' Child Welfare Services/Case Management System.

* A single referral may consist of multiple allegations.

† Allegations that the Los Angeles County Department of Children and Family Services decided not to investigate.

‡ Because data for this table are as of March 2, 2011, most of these allegations may now have a final disposition.

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Appendix B

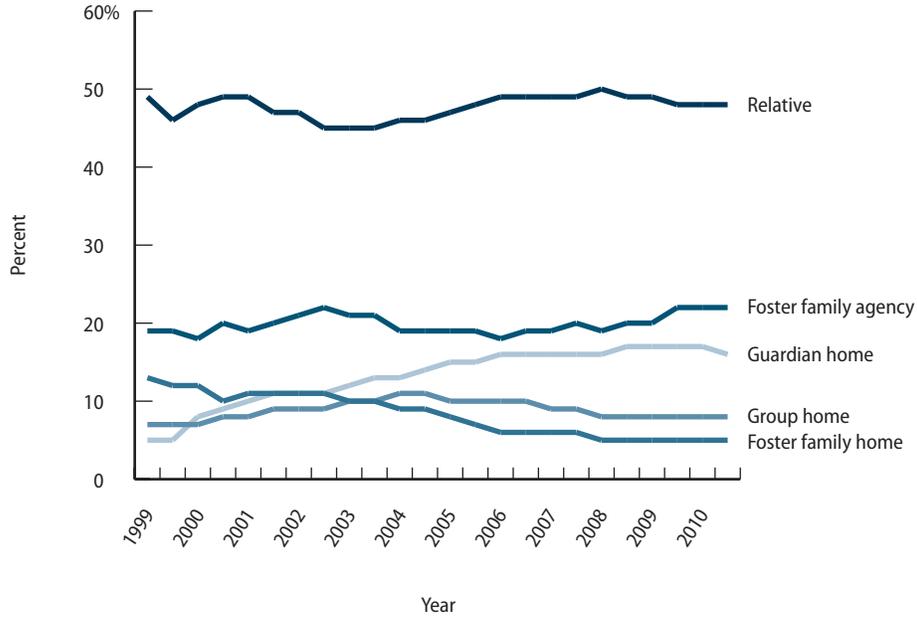
INFORMATION ON LOS ANGELES COUNTY CHILD PLACEMENTS

In Figure B on the following page, we provide information about child placements in Los Angeles County by its five most widely used placement types. The figure shows that the percentage of placements with relatives has remained relatively stable, at around 48 percent since 1999. This percentage is substantially higher than the statewide average of approximately 36 percent.¹⁷

In our October 2011 report, *Child Welfare Services: California Can and Must Provide Better Protection for Abused and Neglected Children* (2011-101.1), we provide information about how the State's increased reliance on foster family agencies has resulted in additional costs to counties and the State. However, this statewide trend has not affected Los Angeles County as much as it has other counties. As indicated in Figure B, the use of foster family agencies in Los Angeles County increased only slightly, from 19 percent in 1999 to 22 percent in 2010. Instead of significant growth in the use of foster family agencies, Los Angeles has experienced a dramatic increase in the use of guardian homes—from 5 percent in 1999 to 16 percent in 2010. According to an acting deputy director, the increased use of guardian homes likely resulted from the Los Angeles County Department of Children and Family Services' increased emphasis on placing children into more permanent homes.

¹⁷ The statewide average includes placements within Los Angeles County. Therefore, the statewide average for placements with relatives would be even lower if Los Angeles County placement totals were removed from the calculation.

Figure B
 Percentage of Los Angeles County Children in Placement by Type
 1999 Through 2010



Source: California State Auditor's analysis of data contained within the California Department of Social Services' Child Welfare Services/Case Management System.

Note: This figure displays percentages for the five major types of placements in Los Angeles County. Other types of placements are not shown.

Appendix C

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

The Joint Legislative Audit Committee directed the California State Auditor 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 Los Angeles County.

Table C
Children With Child Welfare Services History Whose Deaths Resulted From Abuse or Neglect
2008 Through 2010

| | | 2008 | 2009 | 2010 | TOTALS |
|---|---|------|------|------|--------|
| Child Welfare Services (CWS) History Information | | | | | |
| Prior CWS | With child, sibling, or parents | 19 | 27 | 31 | 77 |
| | Referrals on child or sibling within 2 years prior to death | 15 | 18 | 16 | 49 |
| Child Death Information | | | | | |
| Cause(s) of death | Blunt-force trauma or physical abuse | 11 | 12 | 5 | 28 |
| | Suffocation or drowning | 5 | 2 | 6 | 13 |
| | Gunshot or stab wound | 1 | 3 | 4 | 8 |
| | Other | 2 | 10 | 16 | 28 |
| Alleged perpetrator(s)* | Mother | 9 | 18 | 18 | 45 |
| | Father | 2 | 10 | 12 | 24 |
| | Stepfather or mother's significant other | 7 | 3 | 4 | 14 |
| | Foster parent | 1 | 0 | 1 | 2 |
| | Relative care provider | 0 | 2 | 0 | 2 |
| | Other or unknown | 2 | 2 | 3 | 7 |
| Demographic Information | | | | | |
| Gender | Male | 9 | 15 | 22 | 46 |
| | Female | 10 | 12 | 9 | 31 |
| Age | 0–12 months | 4 | 11 | 9 | 24 |
| | 1–2 years | 10 | 5 | 11 | 26 |
| | 3–5 years | 0 | 4 | 2 | 6 |
| | 6–12 years | 4 | 6 | 5 | 15 |
| | 13–18 years | 1 | 1 | 4 | 6 |
| | | | | | |
| Ethnicity | Hispanic or Latino | 7 | 15 | 18 | 40 |
| | African American | 7 | 11 | 9 | 27 |
| | White | 2 | 1 | 3 | 6 |
| | Asian or Pacific Islander | 3 | 0 | 1 | 4 |

Source: Unaudited report from the Los Angeles County Department of Children and Family Services dated October 2011.

* Total number of perpetrators (94) is greater than number of child deaths (77), because some fatalities involved multiple perpetrators.

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Appendix D

RESULTS OF OUR EMPLOYEE SURVEY AT THE LOS ANGELES COUNTY DEPARTMENT OF CHILDREN AND FAMILY SERVICES

To gain an understanding of the work environment at the Los Angeles County Department of Children and Family Services (department), we surveyed over 7,000 department employees in January 2012. We notified employees of this survey by e-mail and collected responses by electronic and other means. On the survey we asked employees to specify whether they strongly agree, agree, disagree, or strongly disagree with the statements listed in Table D. The statements generally regard the department's processes for planning, organizing, directing, and controlling program operations. We computed an average response score for each statement by assigning a score of 4 to "strongly agree" responses, 3 to "agree" responses, 2 to "disagree" responses, and 1 to "strongly disagree" responses. We received nearly 2,600 valid responses from department employees (a 36 percent response rate). We ensured that we included only one response per employee by assigning and requiring a code from each department employee. The aggregate results of this survey, as well as the high and low responses by regional office or unit, are provided in Table D.

Table D

Results of Employee Survey at the Los Angeles County Department of Children and Family Services

| | SURVEY QUESTION | AVERAGE SCORE | HIGH SCORE (OFFICE) | LOW SCORE (OFFICE) |
|--------------------------------------|---|---------------|--|---------------------------|
| Section I—Control Environment | | | | |
| 1 | The Department of Children and Family Services (DCFS) director's office places sufficient emphasis on the importance of integrity, ethical conduct, fairness and honesty in dealings with employees, clients and other organizations. | 3.1 | 3.2 (Compton) | 2.9 (El Monte) |
| 2 | The regional administrator's office places sufficient emphasis on the importance of integrity, ethical conduct, fairness and honesty in dealings with employees, clients and other organizations. | 3.0 | 3.2 (Santa Fe Springs) | 2.8 (West Los Angeles) |
| 3 | My direct supervisor(s) place sufficient emphasis on the importance of integrity, ethical conduct, fairness and honesty in their dealings with employees, clients and other organizations. | 3.3 | 3.6 (West San Fernando Valley) | 3.0 (El Monte) |
| 4 | The DCFS director's office strives to comply with laws, rules and regulations. | 3.2 | 3.3 (Santa Clarita) | 3.1 (El Monte) |
| 5 | The regional administrator's office strives to comply with laws, rules and regulations. | 3.2 | 3.4 (West San Fernando Valley) | 3.0 (West Los Angeles) |
| 6 | My direct supervisor(s) strive to comply with laws, rules and regulations. | 3.4 | 3.7 (West San Fernando Valley) | 3.1 (El Monte) |
| 7 | An atmosphere of mutual trust and open communication between management and employees has been established. | 2.7 | 2.9 (San Fernando Valley) | 2.4 (West Los Angeles) |
| 8 | The acts and actions of management are consistent with the stated values and conduct expected of all other employees. | 2.8 | 3.1 (Asian Pacific and American Indian) | 2.6 (El Monte) |

continued on next page...

| | SURVEY QUESTION | AVERAGE SCORE | HIGH SCORE (OFFICE) | LOW SCORE (OFFICE) |
|---------------------------------------|---|---------------|--|--|
| 9 | My work unit is committed to making decisions free of favoritism or bias. | 3.2 | 3.4 (West San Fernando Valley) | 3.0 (West Los Angeles) |
| 10 | Management is open to suggestions for improvement. | 2.8 | 3.1 (Asian Pacific and American Indian) | 2.7 (West Los Angeles) |
| 11 | I am willing to help identify and address problems and issues that may not be part of my normal duties. | 3.2 | 3.3 (Vermont Corridor) | 3.1 (Asian Pacific and American Indian) |
| 12 | I believe other DCFS employees are generally willing to identify and address problems and issues that may not be part of their normal duties. | 2.9 | 3.0 (Child Protection Hotline) | 2.7 (Asian Pacific and American Indian) |
| 13 | Personnel turnover has NOT impacted my work unit's ability to effectively provide services to clients and/or their families. | 2.6 | 3.0 (Child Protection Hotline) | 2.0 (Compton) |
| 14 | Employees in my work unit are treated fairly and justly. | 3.0 | 3.4 (West San Fernando Valley) | 2.9 (El Monte) |
| Section II—Risk Management | | | | |
| 15 | I am accountable for defined, measurable tasks and objectives. | 3.3 | 3.4 (Santa Clarita) | 3.2 (West Los Angeles) |
| 16 | Management holds staff accountable for defined, measurable tasks and objectives. | 3.1 | 3.3 (West San Fernando Valley) | 3.0 (Child Protection Hotline) |
| 17 | It is always clear to me whom I report to and who oversees my work. | 3.4 | 3.5 (Santa Clarita) | 3.2 (El Monte) |
| 18 | I have sufficient resources, tools and time to perform my job. | 2.7 | 3.0 (Child Protection Hotline) | 2.3 (El Monte) |
| 19 | The objectives and goals of my work unit are reasonable and attainable. | 2.9 | 3.2 (Child Protection Hotline) | 2.5 (El Monte) |
| 20 | Management has given me an appropriate level of authority to accomplish my job. | 3.1 | 3.2 (West San Fernando Valley) | 2.9 (Asian Pacific and American Indian) |
| 21 | Generally, I do not feel unreasonable pressure to make decisions that contrast to the stated mission of the organization. | 3.0 | 3.2 (West San Fernando Valley) | 2.8 (El Monte) |
| 22 | In my work unit, we identify barriers and obstacles and resolve issues that could impact achievement of objectives. | 3.0 | 3.2 (San Fernando Valley) | 2.9 (West Los Angeles) |
| 23 | Management has created safe mechanisms for employees to raise concerns about practices that may put DCFS's reputation at risk. | 2.8 | 2.9 (Asian Pacific and American Indian) | 2.6 (West Los Angeles) |
| Section III—Control Activities | | | | |
| 24 | The policies and procedures in my work unit are clearly stated and allow me to do my job effectively. | 3.0 | 3.2 (Emergency Response Command Post) | 2.8 (Pomona) |
| 25 | Employees who break laws, rules and regulations affecting DCFS will be discovered. | 3.0 | 3.1 (Emergency Response Command Post) | 2.8 (Lancaster) |
| 26 | Employees who break laws, rules and regulations affecting DCFS and are discovered will be subject to appropriate consequences. | 2.9 | 3.2 (San Fernando Valley) | 2.7 (Lancaster) |

| SURVEY QUESTION | | AVERAGE SCORE | HIGH SCORE (OFFICE) | LOW SCORE (OFFICE) |
|---|--|---------------|--|--|
| 27 | My work is adequately supervised. | 3.3 | 3.5 (Child Protection Hotline) | 3.1 (El Monte) |
| Section IV—Information and Communication | | | | |
| 28 | There is a way for me to provide recommendations for process improvements. | 2.9 | 3.1 (Emergency Response Command Post) | 2.8 (Metro North) |
| 29 | The interaction between management and my work unit enables us to perform our jobs effectively. | 2.9 | 3.1 (Asian Pacific and American Indian) | 2.8 (Metro North) |
| 30 | The communication across organizational boundaries within DCFS enables us to perform our jobs effectively. | 2.8 | 3.0 (Asian Pacific and American Indian) | 2.6 (West Los Angeles) |
| 31 | I have sufficient information to do my job. | 3.1 | 3.2 (Emergency Response Command Post) | 3.0 (Metro North) |
| 32 | Management has clearly communicated to me the behavior that is expected of me. | 3.2 | 3.3 (Lancaster) | 3.1 (El Monte) |
| 33 | Management is informed and aware of my work unit's actual performance. | 3.1 | 3.3 (Lancaster) | 3.1 (El Monte) |
| 34 | I know where to report employee misconduct. | 3.1 | 3.3 (Emergency Response Command Post) | 2.9 (Vermont Corridor) |
| 35 | If I report wrongdoing to my supervisor, I am confident the wrongdoing will stop. | 2.9 | 3.1 (Emergency Response Command Post) | 2.7 (West Los Angeles) |
| 36 | Employees who report suspected misconduct are protected from retaliation. | 2.7 | 3.0 (West San Fernando Valley) | 2.6 (El Monte) |
| Section V—Monitoring | | | | |
| 37 | Information reported to management reflects the actual results of operations in my work unit. | 3.0 | 3.1 (West San Fernando Valley) | 2.7 (West Los Angeles) |
| 38 | Internal and/or external feedback and complaints are followed up in a timely and effective manner. | 2.8 | 3.0 (Asian Pacific and American Indian) | 2.7 (Metro North) |
| 39 | We consider consumer complaints and feedback in order to identify quality problems. | 3.0 | 3.2 (Emergency Response Command Post) | 2.8 (Metro North) |
| 40 | Employees in my work unit know what actions to take when they find mistakes or gaps in what we are supposed to do. | 3.0 | 3.3 (Emergency Response Command Post) | 2.9 (Vermont Corridor) |
| 41 | My supervisor reviews my performance with me at appropriate intervals. | 3.2 | 3.4 (Child Protection Hotline) | 3.1 (El Monte) |
| 42 | I know what action to take if I become aware of unethical, illegal or fraudulent activity. | 3.1 | 3.3 (Emergency Response Command Post) | 3.0 (Asian Pacific and American Indian) |

Source: California State Auditor's survey of the Los Angeles County Department of Children and Family Services' employees, conducted January 2012.

Note: 4 = Strongly agree
3 = Agree
2 = Disagree
1 = Strongly disagree

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(Agency comments provided as text only.)

County of Los Angeles
Department of Children and Family Services
425 Shatto Place
Los Angeles, California 90020

March 16, 2012

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 safety and protection of children in Los Angeles County. *The Los Angeles County's Department of Children and Family Services: Management Instability Hampered Efforts to Better Protect Children* (Audit 2011-101.2) audit report takes a constructive and fair look at the policies and practice responsibilities of the Department of Children and Family Services (DCFS). The report appropriately identifies areas where practices can be strengthened and areas for which the Department previously identified areas of need and implemented protocols after the review period. The report appears balanced and strengths-based, acknowledging DCFS' robust death review process, responsiveness to new protocols regarding registered sex offenders, and prudent use of relative and Foster Family Agenda (FFA) placement resources.

DCFS is proud to be a partner in the service of our children and families with our State oversight agency, the California Department of Social Services (CDSS), our County oversight body, the County of Los Angeles Board of Supervisors, and the Bureau of State Audits (BSA). DCFS prides itself not only on being one of the largest agencies in the nation to serve children and families, but also for being an innovative and forward thinking agency in its effort to protect children from abuse and neglect and provide the highest caliber of services along with other County departments and community partners.

DCFS generally agrees with the findings and recommendations of the BSA audit report. Our feedback on specific items in the report and report recommendations are enclosed. Please note that this feedback is in response only to the draft document provided to the Department on March 9, 2011. This morning we received revised language for Chapter 2 with regard to relative placements from Ben Belnap. As our County Counsel has not had sufficient time to review this new language, our enclosed feedback does not respond to this revised language.

DCFS has been positively challenged by BSA's audit process. BSA's questions and insights have fostered healthy discussions within DCFS on how practices can be improved in the best interest of the children and families we serve, and where positive change is needed within DCFS and at the State level (e.g., electronic

* California State Auditor's comments begin on page 81.

Ms. Elaine Howle, State Auditor
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cross-reporting and tracking). DCFS will continue discussions and implement positive changes as a result of this audit, both those prescribed by BSA and those not prescribed by BSA; for this, DCFS is appreciative. If you have additional questions, I can be reached at (213) 351-5602.

Sincerely,

(Signed by: Philip L. Browning)

PHILIP L. BROWNING
Director

Enclosure

Child Protective Services Oversight Audit 2011-101.2 Responses to specific statements, charts, and tables

1. Summary, page 3, paragraph 1, second full sentence

①

The report states: "Our review of 20 placements found that the department, in nine instances, did not complete assessments and background checks before placing children." The Department of Children and Family Services (DCFS) disagrees with this finding as the Department believes it placed a number of these children after properly conducting a relative assessment as mandated in Welfare and Institutions Code (WIC) 309. That is, the Department conducted the mandatory home inspection and clearances as listed in the box on page 28 of the draft report, entitled "Assessment That Must Be Completed Prior to Placement With Relatives." DCFS cites the legal justification for this assertion and will refer back to this legal argument multiple times throughout this section (See below, Legal Justification for Temporary Placements with Relatives).

②

DCFS asserts that in at least four, if not all nine, placements, appropriate assessments and background checks were conducted in accordance with state law (WIC 309). To illustrate, see Figure 7 following page 29 of the draft report. The fifth, twelfth, thirteenth, and nineteenth cases listed indicate that clearances were obtained prior to placement, but that home inspections were not completed. The Department asserts that, based on WIC 309, the Department did, in fact, conduct the required home assessments.

Further, the first, fourth, seventh, fourteenth, and twentieth temporary "placements" pending ASFA may also been lawful. It is unclear whether the audit report is basing its criteria on CLETS and CACI results (as required by WIC 309) or is requiring DOJ Live Scan results prior to placement. As Figure 7 does not specify what type of clearance was deemed "missing" for these five cases by virtue of the shield figure past the point of placement, the Department is unable to verify if these cases were in compliance. In summary, the Department contends that at least 15 cases were in compliance and that with verification, all 20 cases may be in compliance.

③

Legal Justification for Temporary Placements with Relatives:

②

While the terms "detain" and "place" are sometimes used interchangeably, they are not the same under the Law. Different levels of approval are required before detaining a child and placing a child into a home. The term "detention" denotes the time after a child is initially taken into custody by DCFS, as defined by WIC 309(c): "If the child is not released to his or her parent or guardian, the child shall be deemed detained for purposes of this chapter."

Once DCFS takes a child into custody, the law imposes a mandate that DCFS attempt to detain the child with a relative or Non Related Extended Family Member ("NREFM"). WIC 309(d) reads in pertinent part:

"(1) If an able and willing relative, as defined in Section 319, or an able and willing nonrelative extended family member, as defined in Section 362.7, is available and requests temporary detention of the child pending the detention hearing, the county welfare department shall initiate an assessment of the relative's or nonrelative extended family member's suitability, which shall include an in-home inspection to assess the safety of the home and the ability of the relative or nonrelative extended family member to care for the child's needs, and a consideration of the results of a criminal records check conducted pursuant to subdivision (a) of Section 16504.5 and a check of allegations of prior child abuse or neglect concerning the relative or nonrelative extended family member and other adults in the home. Upon completion of

④

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this assessment, ***the child may be placed in the assessed home***. For purposes of this paragraph, and except for the criminal records check conducted pursuant to subdivision (a) of Section 16504.5, the standards used to determine suitability shall be the same standards set forth in the regulations for the licensing of foster family homes.

(2) Immediately following the placement of a child in the home of a relative or a nonrelative extended family member, the county welfare department shall evaluate and approve or deny the home for purposes of AFDC-FC eligibility pursuant to Section 11402. The standards used to evaluate and grant or deny approval of the home of the relative and of the home of a nonrelative extended family member, as described in Section 362.7, shall be the same standards set forth in regulations for the licensing of foster family homes which prescribe standards of safety and sanitation for the physical plant and standards for basic personal care, supervision, and services provided by the caregiver." [emphasis added]

As mandated by 309(d), DCFS Procedural Guide 0100-502.10 contains the following policy language:

④

NOTE: For temporary detentions (i.e., immediate or emergency placement), CWS/CMS searches, CLETS and CACI clearances, **must be done** immediately or, absent any extraordinary circumstances, during the first 23 hours following removal of the child on all relative and non-relative extended family members requesting placement. **Such a temporary detention cannot occur unless the results of the CLETS are obtained and those results respectively reveal no convictions (other than a minor traffic violation) and that the information obtained from searches of CWS/CMS and CACI have been determined not to pose a risk to the child.**

A child **may be** temporarily placed in the home even when it has been determined that an individual has resided in another state in the past five years, pending the receipt of the information from the other state(s).

Such directive is consistent with the provisions of WIC 309(d). Please note that DCFS adds the additional requirement of checking CWS/CMS prior to detention in an effort to ensure the safest and most well informed placement decision possible.

DCFS policy is also in accord with the exclusion from foster care licensure contained in Health and Safety Code section 1505(l)(1) which reads as follows:

1505(l)

"(1) Any home of a relative caregiver of children who are placed by a juvenile court, supervised by the county welfare or probation department, and the placement of whom is approved according to subdivision (d) of Section 309 of the Welfare and Institutions Code."

The legislature recognizes that DCFS has a mandate to detain children with relatives if possible, and permits an expedited procedure for the purpose of the initial emergency detention. DCFS policy and practice are consistent with the requirements for detention.

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Regarding the term "placement," WIC 361.3(a) instructs that when a child is removed from the parents pursuant to WIC 361, "...preferential consideration shall be given to a request by a relative of the child for placement of the child with the relative." Thus "placement" occurs at the time the court removes custody from the parent at the WIC 361 disposition hearing.

WIC 361.4 establishes the legal standard for placing a child with a relative or NREFM. That standard reads:

"(b) Whenever a child may be placed in the home of a relative, or the home of any prospective guardian or other person who is not a licensed or certified foster parent, the court or county social worker placing the child shall cause a state-level criminal records check to be conducted by an appropriate government agency through the California Law Enforcement Telecommunications System (CLETS) pursuant to Section 16504.5. The criminal records check shall be conducted with regard to all persons over 18 years of age living in the home, and on any other person over 18 years of age, other than professionals providing professional services to the child, known to the placing entity who may have significant contact with the child, including any person who has a familial or intimate relationship with any person living in the home. A criminal records check may be conducted pursuant to this section on any person over 14 years of age living in the home who the county social worker believes may have a criminal record. **Within 10 calendar days** following the criminal records check conducted through the California Law Enforcement Telecommunications System, the social worker shall ensure that a fingerprint clearance check of the relative and any other person whose criminal record was obtained pursuant to this subdivision is initiated through the Department of Justice to ensure the accuracy of the criminal records check conducted through the California Law Enforcement Telecommunications System and shall review the results of any criminal records check to assess the safety of the home. The Department of Justice shall forward fingerprint requests for federal-level criminal history information to the Federal Bureau of Investigation pursuant to this section.

(c) Whenever a child may be placed in the home of a relative, or a prospective guardian or other person who is not a licensed or certified foster parent, the county social worker shall cause a check of the Child Abuse Central Index pursuant to subdivision (a) of Section 11170 of the Penal Code to be requested from the Department of Justice. The Child Abuse Central Index check shall be conducted on all persons over 18 years of age living in the home. For any application received on or after January 1, 2008, if any person in the household is 18 years of age or older and has lived in another state in the preceding five years, the county social worker shall check the other state's child abuse and neglect registry to the extent required by federal law.

(d) (1) If the results of the California and federal criminal records check indicate that the person has no criminal record, the county social worker and court may consider the home of the relative, prospective guardian, or other person who is not a licensed or certified foster parent for placement of a child.

(2) If the criminal records check indicates that the person has been convicted of a crime that the Director of Social Services cannot grant an exemption for under Section 1522 of the Health and Safety Code, the child shall not be placed in the home. If the criminal records check indicates that the person has been convicted of a crime that the Director of Social Services may grant an exemption for under Section 1522 of the Health and Safety Code, the child shall not be placed in the home unless a criminal records exemption has been granted by the county, based on substantial and convincing evidence to support a reasonable belief that

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the person with the criminal conviction is of such good character as to justify the placement and not present a risk of harm to the child pursuant to paragraph (3). [emphasis added]

The law adds the requirement for fingerprint clearance checks and FBI criminal history information as a condition for approval for placement, in addition to those items already obtained for detention as directed by WIC 309. This section specifically indicates that the fingerprint clearance check must be submitted within 10 calendar days of the CLETS request submission. That is consistent with DCFS policy and practice, contrary to the contention of the audit on page 8. The additional checks mandated by WIC 361.4 take a substantial amount of time to complete. This procedure makes sense in light of the fact that the disposition hearing must take place no later than sixty (60) days from the time of initial removal (see WIC 352(b)), thereby giving the Department the additional time to complete the full assessment.

- ⑤ By directing that a criminal records check be cleared pursuant to Health and Safety Code section 1522, the legislature reinforced the notion that there is a distinction between a WIC 309 detention (which is excluded from the Health and Safety Code 1522 requirements per Health and Safety 1505) and placement (which must have a license cleared pursuant to Health and Safety 1522).

- ⑥ Unfortunately the audit appears to focus strictly on placements occurring pursuant to WIC 361.4. DCFS policy is consistent with those requirements as well as the legal standards for temporary detention found in WIC 309. DCFS policy complies with both the letter and intent of the law.

2. Summary, page 3, paragraph 1, 5th full sentence

The report states: "This delay resulted in nearly 900 children living in placements that the department later determined to be unsafe or inappropriate." DCFS asserts that the report's language here does not account for removals which were not due to inappropriate or unsafe circumstances. There may have been other factors leading to a removal, such as a child needing a higher level of care, return of a child to a parent, replacement with a sibling, a or a caretaker's unwillingness to continue care for a child due to fiscal, health, or other personal factors. DCFS does not believe that a relative home that has received an initial assessment as required by the law (including home inspection and review of criminal and child abuse clearances) but has not yet been approved by the Department's ASFA Section is "unsafe" simply because all ASFA approval conditions have not been met. "The use of the term "unsafe" may be appropriate because the home may subsequently be assessed to be "unsafe." However, just because a child was removed from a home does not mean it was "unsafe" or even "inappropriate." DCFS asserts that BSA has not established how many of the 900 removals were the result of an inappropriate or unsafe home.

⑦

3. Summary, page 3, paragraph 2, 1st full sentence

The report states: "Department data indicate that not completing timely investigations and placement assessments has been a long-standing problem." DCFS agrees that timely investigations have historically been a problem to varying levels. However, DCFS had never experienced such a relatively rapid increase of untimely investigations to highest historical level - beginning in early 2010 and peaking in July 2010. This unique trend pattern prompted DCFS to the realization that our safety enhancements and new protocols resulting from external sources were becoming overwhelming at a 30-day expectation and led DCFS to inform CDSS of these conditions, to discuss solutions, and to request a formal and temporary waiver of the 30-day regulation. DCFS needed time to adjust to the new higher internal safety and service standards and externally-driven policy changes, move staff to accommodate the increased workload, and incrementally

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stabilize back to the 30-day standard. CDSS approved the 30-day waiver in recognized faith that the safety and service enhancements were credible and of value to the children and families of Los Angeles. CDSS has regularly and formally monitored DCFS' efforts to achieve higher standards of investigation in incrementally less time while maintaining the enhancements as promised.

⑧

4. Summary, page 3, paragraph 2, last sentence

The report states: "Although the department obtained temporary approval from Social Services for its 60-day investigatory time frame, we believe that neither of these revised policies and measurements have served the Department well in its efforts to improve the timeliness of its services and provide for the safety of children." DCFS asserts that both the timeliness of services and the quality of safety and services for children has drastically improved since the CDSS waiver was granted. DCFS has decreased investigations over 60-days from over 6200 in July 2010 to 900 at the end of February 2012. DCFS has decreased investigations over 30-day from over 9300 in July 2010 to 2900 in February 2012. Furthermore, DCFS believes that BSA has done very little, if no, comparative analysis of the quality of ER services in 2009 to services since the waiver to justify the assertion that improvements have not been made.

⑨

⑩

5. Summary, page 4, paragraph 2, 3rd sentence

The report states: "Of the eight cases that required a report to DOJ, the department submitted only three." DCFS believes that more than 3 of the 8 cross-reports were sent to DOJ. Unfortunately DCFS did not retain copies of these reports in the hardcopy case records. DCFS began requiring that copies of the cross-reports must be maintained in the record after the BSA's audit period. The only way that complete verification can be done is to submit the referral numbers and perpetrator names from the missing 5 cross-reports to DOJ for a cross-check. DOJ does not send us a tracking report, and DCFS does not electronically or physically track these cross-reports, nor does DCFS use registered return receipt mailing to track compliance. To illustrate, a similar instance where a cross-report was not found in the file for a required CCL cross-report occurred during this audit. DCFS contacted our CCL Analyst to confirm that the cross-report was made. DCFS requested the proof of the cross-report from CCL in this one instance, CCL provided proof to DCFS, and DCFS provided the evidence to BSA. DCFS has changed cross-report protocols since the period under review, but the current system is not fail-proof. In fact this audit has prompted DCFS to look for even better ways to ensure DOJ cross-reporting in all appropriate situations. DCFS looks forward to the day when the DOJ cross-reports can be electronically generated and securely sent to DOJ with a tracking mechanism possibly linked to CWS/CMS.

⑪

6. Summary, page 6, two-part recommendation 1

DCFS agrees with this recommendation and respectfully refers the reader to the recommendation response to 1.1 in the section below.

7. Summary, page 6, recommendation 2

DCFS agrees in principal with this recommendation but in accordance with WIC 309(d) AND WIC 361.3 & 4. DCFS respectfully refers the reader to the recommendation response to 2.1 in the section below and #1 in this section above.

8. Summary, page 6, recommendation 3

DCFS agrees with this recommendation and respectfully refers the reader to the recommendation response to 2.3 in the section below.

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9. Summary, page 6, recommendation 4

DCFS agrees with this recommendation and respectfully refers the reader to the recommendation response to 3.2 in the section below.

10. Introduction, page 7, paragraph 1, 3rd full sentence

⑫

The report states: "Generally, the department provides family preservation services, removes children from unsafe homes, temporarily places these children with relatives or foster homes, and facilitates legal guardianship or adoption of these children into permanent families when appropriate." DCFS recommends that the sentence includes the following phraseology: "with relatives or foster homes, provides family reunification services, and facilitates . . ."

11. Introduction, page 9, paragraph 1, 3rd and 4th full sentences

⑬

The report states: "In this situation, 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 . . ." DCFS recommends that the "parent" be identified as a "non-offending" parent in both sentences and in the text box to the right of the text.

12. Introduction, pages 11-12 last full paragraph and page 15 last paragraph, 2nd full sentence

⑭

Rather than simply saying that the County initially refused access or withheld documents invites the reader to speculate as to the County's motive and conclude that its motive was improper. DCFS recommends that BSA acknowledge that a legitimate dispute existed. The report should read something to the effect that "Los Angeles County initially refused us access to certain privileged communications necessary for our audit. The County's reason for denying access was that our access statute, Government Code section 8545.2, did not, at that time, explicitly authorize us to access privileged communications. That statute was subsequently amended to clarify our right of access, at which point the County gave us access to those documents. Nevertheless, this resulted in a delay in our audit work related to Los Angeles County's CWS agency."

13. Chapter 1, page 16, paragraph 1, last full sentence

⑮

The report states: "the department redefined the problem on more favorable terms." DCFS asserts that the CDSS 30-day waiver was requested and granted due to significant and numerous new ER safety and service enhancements and new externally-driven protocols, e.g. 9th Circuit ruling, Katie A settlement, which were implemented in 2009 and 2010. DCFS was not seeking favor from the state, but open communication with CDSS and agreed upon solutions. The reader is respectfully referred to further discussion under #3 and #4 above in this section and the response to recommendation 1.1 below.

14. Chapter 1, page 17, 1st full sentence

⑯

The report states: "Nevertheless, the backlog still totaled 3,200 uncompleted investigations as of January 2012." DCFS asserts that uncompleted investigations in January 2012 should be measured according to the CDSS approved waiver that was in place at this time. It appears that BSA is rescinding the waiver on behalf of CDSS. In other words, this measure should be stated in terms of the 60-day standard, namely 1,000 uncompleted investigations in January 2012 or 800 in March 2012.

15. Chapter 1, page 17, paragraph 3 and following

⑰

The report measures DCFS' performance on referral response times, but does not acknowledge that an attempted contact is an appropriate response. DCFS asserts that an attempted contact should count as an

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acceptable response. An attempted in-person contact is not a failed response, but a failed in-person contact. Division 31 regulations do not mandate a completed contact timeframe, only a response timeframe.

16. Chapter 1, page 18, paragraph 1 and Table 1

As with response #15 above, DCFS asserts that performance on timely response should be measured according to the mandated response completion and not the completion of the in-person contact. DCFS does not control whether or not a family is home at the time of the response and should not be measured accordingly. DCFS agrees that the in-person contact is the key ingredient in a successful assessment of a child's safety. In order to maximize the success of timely responses, DCFS has instituted policies beyond Division 31 regulations which mandate timeframes for subsequent attempts when initial attempts fail.

18

17. Chapter 1, page 20, paragraph 1

The report states: "Within the first 21 days of a referral being opened, a social worker was required to make three in-person contacts with each child, instead of three in-person contacts within 30 days." As stated in the February 2011 letter to CDSS, three contacts in 21 days was never intended to be a safety enhancement or a change of Division 31 regulations when the initial April 2010 request for a 30-day waiver was submitted. Within the April 2010 letter there are two references to timeframes in the first 30-days, i.e., one states 3 in 30 days and the other inadvertently states 21 days. The only clarification DCFS was seeking in the April 2010 waiver request letter was affirmation that one additional contact would be required under the waiver during the 31-60 day period. DCFS contends that the report should not perpetuate the inadvertent error in DCFS' April 2010 letter. This was a misunderstanding which DCFS never intended and in September 2011 CDSS affirmed that this was not a part of the waiver. Furthermore, there exists a common misunderstanding, even within DCFS policy, that 3 contacts are required on all referrals open 30 days (or a minimum of 2 within 21 days), but in fact the Division 31 requirement only applies to children who have been indentified as substantiated victims of abuse and/or neglect and for whom a case has been opened and a written case plan for ongoing services has been completed. BSA's sampled cases do not distinguish between children with or without ongoing open case services, but neither does current DCFS policy. DCFS has requested specific clarification on this matter and is awaiting a reply from CDSS. Until a response is formally received, DCFS does not recommend changing the report to reflect these variables.

19

18. Chapter 1, page 21, 2nd full sentence

The report states: "... the 60-day waiver request appears to have been more about redefining an existing problem under more favorable terms than providing better services." DCFS disagrees with this assertion and the reader is respectfully referred to further discussion to refute the report's statement under #3, #4, and #13 above in this section and the response to recommendation 1.1 below.

9

19. Chapter 1, page 21, paragraph 1, 2nd sentence

DCFS again recommends that BSA's measurements of a "backlog" be reported only for referrals that are over 60 days when the report is referencing a time period during the approved waiver of the Division 31 30-day requirement from CDSS. The reader is respectfully referred to the recommended detailed changes in #14 above in this section.

16

20. Chapter 1, page 21, Figure 4

The report displays a 3-year timeline regarding the number of over 30-day and over 60-day referrals with highlighted events deemed to have impacted the number of referrals out of compliance. DCFS recommends that under subscript #1, July 2009, reflect that SDM risk assessments were also required on all unfounded

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- ⑳ referrals at this time. Further, the information listed under Subscript #8 should be moved up as allowing social workers to work overtime to address the ER backlog occurred during April 2010, not April 2011. It should be noted that there were numerous other factors impacting the ER backlog that are not reflected in Figure 4. If required, DCFS' Policy Section can provide the dates for the safety protocol enhancements.

21. Chapter 1, 1st bullet, 2nd and 3rd sentences

- ⑬ The report states: "In February 2011 the department revised its investigation narrative template, making many fields pre-populated. According to the department, this change provided social workers more time to write comprehensive investigative narratives." DCFS recommends that the sentences be revised to state that "In February 2011, the department revised its investigation narrative template to standardize documentation across the department and streamlined the narrative to reduce duplication of content already in CWS/CMS contacts. The revised investigation narrative also required social workers to provide comprehensive summaries. These summaries outline the critical factors and critical reasoning used during the investigation for dispositional decisions. In addition, the department created a standardized supervisor review tool with hyperlink features that connect supervisors and social workers to relevant policy for each referral closure requirement."

22. Chapter 1, page 23, last paragraph, last full sentence

- ⑳ The report states: "Department officials also stated that in April 2011" overtime was offered to staff. DCFS asserts that the date should be changed to April 2010.

23. Chapter 1, page 24, last paragraph, 1st sentence

- ⑬ The report states: "Departmental policies require social workers to use specific assessment tools for various tasks." CDSS mandates the use of standardized assessment tools. DCFS uses one of two State-authorized tools called Structure Decision-Making which is also used in approximately 54 other counties. Thus DCFS recommends that the statement reflect that structured tools are required by CDSS, and that DCFS utilizes Structured Decision-Making along with approximately 54 other counties.

24. Chapter 1, page 26, Recommendation 1

DCFS generally agrees with this recommendation and respectfully refers the reader to the recommendation response to 1.1 in the section below.

25. Chapter 1, page 26, Recommendation 2

DCFS agrees with this recommendation and respectfully refers the reader to the recommendation response to 1.2 in the section below.

26. Chapter 2, page 27, paragraph 1, 1st sentence

- ② The report states: "Los Angeles County's Department of Children and Family Services (department) did not consistently complete requisite assessments and background checks before placing children with ..." DCFS disagrees with this statement and respectfully refers the reader to #1 above in this section for further reasoning.

27. Chapter 2, page 27, paragraph 1, 2nd sentence

- ③ The report states: "... the department completed less than a third of required assessments and background checks prior to placing ..." DCFS disagrees with this statement and respectfully refers the reader to #1 above in this section for further reasoning. DCFS contends that significantly more at least 15 of the 20, and possibly all 20, cases involved lawful temporary placements with relatives.

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28. Chapter 2, page 27, paragraph 1, 3rd sentence

The report uses “unsafe or inappropriate” terms without supporting assessment facts. DCFS disagrees with the use of “unsafe or inappropriate” language and respectfully refers the reader to #2 above in this section for further reasoning.

⑦

29. Chapter 2, page 27, paragraph 1, 3rd sentence

The report again uses “unsafe or inappropriate” terms without supporting facts. DCFS disagrees with this language and respectfully refers the reader to #2 above in this section for further reasoning.

⑦

30. Chapter 2, page 27, paragraph 1, 2nd to last sentence

The report states: “unsafe homes . . . did not always notify appropriate oversight entities” DCFS again disagrees with the “unsafe” language and respectfully refers the reader to #2 above in this section for further reasoning. Also, DCFS believes that it may have provided appropriate notification to DOJ in more or all circumstances, but DOJ has not been contacted to verify this assertion. The reader is respectfully referred to #5 above in this section for further reasoning.

⑦

⑪

31. Chapter 2, page 27, paragraph 2, 1st sentence

The report states: “The department did not consistently complete requisite assessments and background checks before placing children with . . .” DCFS disagrees with this statement and respectfully refers the reader to #1 above in this section for further reasoning.

②

32. Chapter 2, page 27, paragraph 2, 2nd sentence

The report states: “Nine out of 20 . . .” DCFS disagrees with this statement and respectfully refers the reader to #1 above in this section for further reasoning. DCFS disagrees with this statement and respectfully refers the reader to #1 above in this section for further reasoning. DCFS contends that significantly more at least 15 of the 20, and possibly all 20, cases involved lawful temporary placements with relatives.

②

③

33. Chapter 2, page 27, paragraph 2, 2nd sentence

The report states: “Nine out of 20 . . .” DCFS disagrees with this statement and respectfully refers the reader to #1 above in this section for further reasoning. DCFS disagrees with this statement and respectfully refers the reader to #1 above in this section for further reasoning. DCFS contends that significantly more at least 15 of the 20, and possibly all 20, cases involved lawful temporary placements with relatives.

②

③

34. Chapter 2, page 28, paragraph 1, 3rd sentence

The report states: “. . . violating state law . . .” DCFS disagrees with this statement and respectfully refers the reader to #1 above in this section for further reasoning.

②

35. Chapter 2, page 28, text box

DCFS believes that clarification of WIC 309 temporary detentions and WIC 341.3 & 4 placements should be made and distinguished. DCFS recommends that an asterisk be placed after the sentence #2 (DOJ Live-Scan results) for WIC 309 temporary detentions. DCFS respectfully refers the reader to #1 above in this section for further reasoning.

⑫

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36. Chapter 2, page 28, last paragraph, last sentence, and 1st sentence that follows on page 29, and Figure 7

- ② The report states: "... nine out of 20 ..." DCFS disagrees with this statement and respectfully refers the reader
③ to #1 above in this section for further reasoning. DCFS contends that significantly more at least 15 of the 20, and possibly all 20, cases involved lawful temporary placements with relatives.

37. Chapter 2, page 29, paragraph 1, and following & Figure 7

- ③ The report states: "... in five instances ..." before the department performed all necessary criminal history checks ... DCFS disagrees with this statement and asserts CLETS and CACI were submitted in compliance with the law, fulfilling the requirements for those homes for which DCFS provided these documents to BSA. DCFS respectfully refers the reader to #1 above in this section for further reasoning.

38. Chapter 2, page 30, first partial paragraph, last sentence

- ②② The report states: "We recognize that emergency placements can take place for which actual placement can precede final approval, but our review of information in CWS/CMS found that only a small fraction of placements were identified as emergency placements." DCFS disagrees with methodology behind this statement and asks BSA to define emergency placement. DCFS asserts that a vast majority of placements are done on an emergency basis and only pre-planned removals, such as a replacement to a higher level of care (from a relative or extended family member), qualify as non-emergent. Further, DCFS does not believe that a field in CWS/CMS which is completed by an eligibility worker is the best way to assess whether or not a placement is emergent. The WIC 300 or WIC 387 Detention Report would best serve to assess the emergent nature of a "placement."

39. Chapter 2, page 30, Figure 8

- ②③ The report provides timeframes for 900 placements according to when they were "assessed." DCFS disagrees with the methodology, legal basis of the Figure, and the inference that assessments were not made timely leaving children vulnerable as this does not account for WIC 309 temporary detention assessment requirements and DCFS practices. DCFS respectfully refers the reader to #1 above in this section for further reasoning.

40. Chapter 2, page 30, last paragraph, 1st sentence

- ⑦ The report states: "... were determined to be unsafe or inappropriate." DCFS disagrees with the "unsafe or inappropriate" language and respectfully refers the reader to #2 above in this section for further reasoning.

41. Chapter 2, page 31, last paragraph, 2nd to last sentence

- ② The report states: "... the department monitors compliance with its internal policy, which is less stringent than state law." DCFS disagrees with this statement and asserts that our policy fully adheres to the letter and intent of state law. DCFS respectfully refers the reader to #1 above in this section for further reasoning.
②①

42. Chapter 2, page 31, last paragraph, last sentence

- ②④ The report states: "The department's policy is to complete caregiver and home assessments within 30 days, regardless of whether the child is already placed." DCFS asserts that this policy is in accordance with state law (cf. #1 above in this section) and complies with CDSS ACL Errata 05-13 dated February 15, 2006, which provides the 30-day timeframe in response to the Higgins v Saenz Settlement (the "Higgins Agreement"). County Counsel has reviewed this policy and concurs that it is compliance with the law.

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43. Chapter 2, page 32, paragraph 1, last sentence

The report states: "... the department needs to measure and monitor its performance relative to state law, which requires these assessments to take place before placement." DCFS asserts that its policy is in accordance with state law (cf. #1 above in this section) and complies with CDSS ACL Errata 05-13 dated February 15, 2006. The practices of the deputy director to progressively reduce a backlog assessments conducted by the Department's ASFA Section did not determine DCFS policy; the ACL and state law did.

24

44. Chapter 2, page 34, Table 3

Table 3 shows the results of registered sex offender (RSO) address matches. DCFS recommends that an update to the table be included in the audit report; this update was recently sent to BSA and reports that one RSO was sickly and frail, lived in a trailer and has died since last report. Also, it should be noted that ASFA regulations do not apply to guardians or where court jurisdiction is closed.

13

45. Chapter 2, page 36, paragraph 2, 2nd sentence

The report discusses the results of three registered sex offender (RSO) address matches where the RSOs lived in separate structures on the property with children nearby. DCFS recommends that an update to the table be included; this update was recently sent to BSA and reported that one RSO who was sickly, frail, lived in a trailer and has since died.

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46. Chapter 2, page 37, paragraph 2, 3rd sentence

The report states: "Of the eight cases we reviewed that required such a report to the DOJ, the department submitted only three." DCFS contends that more than 3 cross-reports may have been submitted and that the only way to be certain of BSA's statement is to cross check the referral numbers and perpetrators with DOJ records. The reader is respectfully referred to further discussion under #5 above in this section.

11

47. Chapter 2, page 37, paragraph 2, 4th sentence

The report states: "In one of the five unreported cases, the department removed a child from the care of a relative due to a substantiated allegation of physical abuse, but the department subsequently placed the child back in the home with the same relative." DCFS recommends that BSA consider providing more case specific information about the nature of the allegation, the time period between the substantiated event and replacement, whether the relative obtained treatment services before the replacement was made, whether the prior allegation was known to the replacement worker from CWS/CMS, and whether the prior allegation was assessed and determined to present no (then) current risk to the child. Often parents are reunified with their children after substantiated allegations and so are guardians and sometimes relatives. It is difficult to know without the specific case details how inappropriate or appropriate the replacement was. DCFS would like to be provided the specific case name and number for follow-up reasons. Nevertheless, DCFS agrees that a DOJ cross-report should have been made upon a substantiated physical abuse allegation.

13

48. Chapter 2, page 38, Figure 9

Figure 9 displays child deaths in Los Angeles resulting from abuse or neglect with and without prior child welfare history from 2008 through 2010. DCFS respectfully requests that a footnote with the definition of "with prior CWS history" be included, i.e. prior cases or referrals on the deceased child, the child's sibling(s), or the child's parent(s) whether the prior CWS history occurred in Los Angeles County or another county in the state.

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49. Chapter 2, page 40, first partial sentence

- ⑬ The reports states: "after-hours county hotline." DCFS recommends that it should state "after-hours Emergency Response Command Post."

50. Chapter 2, page 40, Recommendation 1

DCFS questions this recommendation and believes policies are consistent with State Law. Please see the recommendation response to 2.1 in the section below and #1 above in this section.

51. Chapter 2, page 40, Recommendation 2

DCFS agrees in principal with this recommendation and respectfully refers the reader to the recommendation response to 2.2 in the section below.

52. Chapter 2, page 40, Recommendation 3

DCFS concurs with this recommendation and respectfully refers the reader to the recommendation response to 2.3 in the section below.

53. Chapter 2, page 40, Recommendation 4

DCFS agrees with this recommendation and respectfully refers the reader to the recommendation response to 2.4 in the section below.

54. Chapter 2, page 40, Recommendation 4

DCFS agrees with this recommendation and respectfully refers the reader to the recommendation response to 2.4 in the section below.

55. Chapter 3, page 49, Recommendation 1

DCFS agrees with this recommendation and respectfully refers the reader to the recommendation response to 3.1 in the section below.

56. Chapter 3, page 49, Recommendation 2

DCFS agrees with this recommendation and respectfully refers the reader to the recommendation response to 3.2 in the section below.

57. Appendix B, page 51, paragraph 2, last sentence

- ⑬ The report states that an increase in guardian homes likely resulted in an increased emphasis on placing children into more permanent homes. DCFS posits that, in addition to an emphasis on permanency, the increase is likely related to the establishment of KinGAP and incentives to caregivers to close-out court jurisdiction with continued placement funding and closed DCFS permanent placement services. DCFS recommends that the report be modified to reflect the impact of KinGAP on the increase of guardianships.

58. Appendix C, page 52, Table C

- ⑬ The report's Table displays child deaths in Los Angeles resulting from abuse or neglect with and without prior child welfare history, cause of death, alleged perpetrator information, and demographic information from 2008 through 2010. DCFS recommends that two notes be added beneath Table C, one to clarify what "with child welfare services history" means and one to clarify that the categories for "cause(s) of death" and "alleged perpetrator(s)" were consolidated by BSA from information provided by DCFS. DCFS respectfully requests that the first footnote delineate what "with prior CWS history" means, i.e. prior cases or referrals on the deceased child, the child's sibling(s), or the child's parent(s) whether the prior CWS history occurred in Los Angeles County or another county in the state.

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**Department of Children and Family Services (DCFS)
Responses to Recommendations
in the Child Protective Services Oversight Audit 2011-101.2**

- 1.1 To ensure that child abuse and neglect allegations receive timely resolution, the department should do the following:**
- **Continue to monitor the status of its backlog of investigations but revise its policies and performance measures to no longer define the backlog as investigations over 60 days old. Rather, it should emphasize completing investigations within 30 days.**
 - **Assess whether it needs to permanently allocate more resources to investigate allegations of child abuse and neglect.**

DCFS agrees in principal with the recommendation and has prepared for the end of the temporary state waiver extending the safe disposition of referrals from 30 days to 60 days through June 30, 2013. DCFS' current long-term tracking tool for ER referrals, the data dashboard, measures the disposition of referrals at the 30 day period according to Division 31 regulations. This data dashboard information is discussed at monthly DCFS STATS meetings attended by approximately 100 regional and support services managers. The tracking tools used during the waiver period are temporary tools to measure performance of managers and line staff. The job performance of the Chief Deputy Director, Deputy Directors, and Regional managers has been measured in FY10-11 and FY11-12 in relation to delinquent investigations. DCFS believes its strategies to reduce the backlog from July 2010 at over 6200 referrals over 60 days to approximately 800 to date have been effective thus far.

DCFS believes that ER enhancements and local and state policy changes led to the "backlog" of referrals in 2009-10. The safety enhancements and changes included but were not limited to the following:

- Assistant Regional Administrator review of significant numbers of qualifying referral conditions.
- The use of the Structured Decision Making (SDM) risk assessment on all "unfounded" referrals above and beyond state SDM policy.
- The full implementation of Point of Engagement policies, including the use of Up-Front assessments on all referrals related to domestic violence, drug and/or alcohol abuse, and mental health issues, the expanded use of Team Decision Making, and enhanced preventive services.
- The renewed focus and use of Family and Children's Index (FCI) for every person residing in the household and use of CLETS to assess all referrals related to physical abuse, sexual abuse, substance abuse, domestic violence, exploitation, and other conditions.
- Expanded protocols in the use of collateral contacts for child safety assessment and service provision.
- Expansion of the scope of investigation from stated referral allegations to a full assessment of all risks to a child's safety, such as any CAN allegation, pool safety, sleeping arrangements, and all persons having significant contact with the child.
- Expanded documentation requirements on all referrals.
- Implementation of new protocols from the 9th Circuit's ruling which had significant practice implications for access to alleged victims in neutral settings, i.e. schools, and changed timeframes on when and how social workers engaged families, and increased the need for County Counsel consultation and dependency warrants to investigate referrals.

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- Implementation of new protocols on new cases related to the Katie A lawsuit settlement, Multi-disciplinary Assessment Team, child support determinations, dependency court photograph history and visitation requirements, and ASFA and Adam Walsh requirements.

In response to the growing backlog and increased workload in ER, DCFS conducted numerous strategy, business process reengineering and policy meetings; and moved staff to ER functions. Beginning in early in 2010, DCFS trained and permanently redeployed social workers from other assignments to ER services. In addition, DCFS trained and permanently reassigned staff from other primary service functions to ER services. In total, DCFS added approximately 190 new ER social workers and 31 supervisors to the ER function. In addition, DCFS added one Assistant Regional Administrator to ER sections for each regional office. Further, DCFS temporarily reassigned approximately 330 social workers and Children Service Administrators in five phases and hired approximately 93 temporary social workers to assist with the backlog, help permanent staff adjust to protocol changes, and achieve sustainable safety enhancements within acceptable state timeframes. DCFS anticipates that safe, sustainable dispositions at the 30-day timeframe will occur in the next fiscal year barring any major protocol changes from outside stakeholders. DCFS believes that we are providing a higher level of child safety and ER services as a result of changes occurring in 2009 and 2010 that continue to present. DCFS plans to test and pilot the use of smart phones and Dragon-Speak software to effectively streamline time intensive data entry tasks so that referrals can be closed more timely and efficiently.

As of March 12, 2012, Los Angeles County ranked 24th out of the 58 California counties for referrals open over 30 days based on contact date according to SafeMeasures. The State average for open over 30 day referrals based on contact date is 31%, while Los Angeles has 33.3% open over 30 days. As of March 12, 2012, 8.4% of Los Angeles County's referrals were open over 60 days (ranked 34th in the State). DCFS intends to continue to improve its over 30-day ranking while ensuring the highest levels of child safety and preventive services.

1.2 To better ensure that inner-city regional offices are staffed by experienced social workers, the department should consider providing incentives to work in these areas or require them to remain in these offices for a period longer than one year currently required.

DCFS agrees with this recommendation and expects to determine the issues related to transfer conditions for social workers during upcoming contract negotiations between the County's Chief Executive Office (CEO) and local Service Employees International Union (SEIU) 721. DCFS has engaged in preliminary discussions with the CEO regarding incentive pay for offices experiencing retention issues.

2.1 To ensure that it is placing children in safe homes, the department should measure its performance and adjust its practices to adhere to state law, which requires that all homes be assessed prior to the placement of the child.

DCFS respectfully disagrees with BSA's assertion that our relative placement policies do not adhere to State Law and believes that Chapter 2 needs modification concerning DCFS' completion of initial background, home, and caretaker assessments according to our County Counsel's assessment, as follows.

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Legal Justification for Temporary Placements with Relatives:

②

While the terms “detain” and “place” are sometimes used interchangeably, they are not the same under the Law. Different levels of approval are required before detaining a child and placing a child into a home. The term “detention” denotes the time after a child is initially taken into custody by DCFS, as defined by WIC 309(c): “If the child is not released to his or her parent or guardian, the child shall be deemed detained for purposes of this chapter.”

Once DCFS takes a child into custody, the law imposes a mandate that DCFS attempt to detain the child with a relative or Non Related Extended Family Member (“NREFM”). WIC 309(d) reads in pertinent part:

“(1) If an able and willing relative, as defined in Section 319, or an able and willing nonrelative extended family member, as defined in Section 362.7, is available and requests temporary detention of the child pending the detention hearing, the county welfare department shall initiate an assessment of the relative’s or nonrelative extended family member’s suitability, which shall include an in-home inspection to assess the safety of the home and the ability of the relative or nonrelative extended family member to care for the child’s needs, and a consideration of the results of a criminal records check conducted pursuant to subdivision (a) of Section 16504.5 and a check of allegations of prior child abuse or neglect concerning the relative or nonrelative extended family member and other adults in the home. Upon completion of this assessment, ***the child may be placed in the assessed home***. For purposes of this paragraph, and except for the criminal records check conducted pursuant to subdivision (a) of Section 16504.5, the standards used to determine suitability shall be the same standards set forth in the regulations for the licensing of foster family homes.

④

(2) Immediately following the placement of a child in the home of a relative or a nonrelative extended family member, the county welfare department shall evaluate and approve or deny the home for purposes of AFDC-FC eligibility pursuant to Section 11402. The standards used to evaluate and grant or deny approval of the home of the relative and of the home of a nonrelative extended family member, as described in Section 362.7, shall be the same standards set forth in regulations for the licensing of foster family homes which prescribe standards of safety and sanitation for the physical plant and standards for basic personal care, supervision, and services provided by the caregiver.” [emphasis added]

As mandated by 309(d), DCFS Procedural Guide 0100-502.10 contains the following policy language:

NOTE: For temporary detentions (i.e., immediate or emergency placement), CWS/CMS searches, CLETS and CACI clearances, **must be done** immediately or, absent any extraordinary circumstances, during the first 23 hours following removal of the child on all relative and non-relative extended family members requesting placement. **Such a temporary detention cannot occur unless the results of the CLETS, are obtained and those results respectively reveal no convictions (other than a minor traffic violation) and that the information obtained from searches of CWS/CMS and CACI have been determined not to pose a risk to the child.**

④

A child **may be** temporarily placed in the home even when it has been determined that an individual has resided in another state in the past five years, pending the receipt of the information from the other state(s).

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Such directive is consistent with the provisions of WIC 309(d). Please note that DCFS adds the additional requirement of checking CWS/CMS prior to detention in an effort to ensure the safest and most well informed placement decision possible.

DCFS policy is also in accord with the exclusion from foster care licensure contained in Health and Safety Code section 1505(l)(1) which reads as follows:

1505(l)

"(1) Any home of a relative caregiver of children who are placed by a juvenile court, supervised by the county welfare or probation department, and the placement of whom is approved according to subdivision (d) of Section 309 of the Welfare and Institutions Code."

The legislature recognizes that DCFS has a mandate to detain children with relatives if possible, and permits an expedited procedure for the purpose of the initial emergency detention. DCFS policy and practice are consistent with the requirements for detention.

Regarding the term "placement," WIC 361.3(a) instructs that when a child is removed from the parents pursuant to WIC 361, "...preferential consideration shall be given to a request by a relative of the child for placement of the child with the relative." Thus "placement" occurs at the time the court removes custody from the parent at the WIC 361 disposition hearing.

WIC 361.4 establishes the legal standard for placing a child with a relative or NREFM. That standard reads:

"(b) Whenever a child may be placed in the home of a relative, or the home of any prospective guardian or other person who is not a licensed or certified foster parent, the court or county social worker placing the child shall cause a state-level criminal records check to be conducted by an appropriate government agency through the California Law Enforcement Telecommunications System (CLETS) pursuant to Section 16504.5. The criminal records check shall be conducted with regard to all persons over 18 years of age living in the home, and on any other person over 18 years of age, other than professionals providing professional services to the child, known to the placing entity who may have significant contact with the child, including any person who has a familial or intimate relationship with any person living in the home. A criminal records check may be conducted pursuant to this section on any person over 14 years of age living in the home who the county social worker believes may have a criminal record. **Within 10 calendar days** following the criminal records check conducted through the California Law Enforcement Telecommunications System, the social worker shall ensure that a fingerprint clearance check of the relative and any other person whose criminal record was obtained pursuant to this subdivision is initiated through the Department of Justice to ensure the accuracy of the criminal records check conducted through the California Law Enforcement Telecommunications System and shall review the results of any criminal records check to assess the safety of the home. The Department of Justice shall forward fingerprint requests for federal-level criminal history information to the Federal Bureau of Investigation pursuant to this section.

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(c) Whenever a child may be placed in the home of a relative, or a prospective guardian or other person who is not a licensed or certified foster parent, the county social worker shall cause a check of the Child Abuse Central Index pursuant to subdivision (a) of Section 11170 of the Penal Code to be requested from the Department of Justice. The Child Abuse Central Index check shall be conducted on all persons over 18 years of age living in the home. For any application received on or after January 1, 2008, if any person in the household is 18 years of age or older and has lived in another state in the preceding five years, the county social worker shall check the other state's child abuse and neglect registry to the extent required by federal law.

(d) (1) If the results of the California and federal criminal records check indicates that the person has no criminal record, the county social worker and court may consider the home of the relative, prospective guardian, or other person who is not a licensed or certified foster parent for placement of a child.

(2) If the criminal records check indicates that the person has been convicted of a crime that the Director of Social Services cannot grant an exemption for under Section 1522 of the Health and Safety Code, the child shall not be placed in the home. If the criminal records check indicates that the person has been convicted of a crime that the Director of Social Services may grant an exemption for under Section 1522 of the Health and Safety Code, the child shall not be placed in the home unless a criminal records exemption has been granted by the county, based on substantial and convincing evidence to support a reasonable belief that the person with the criminal conviction is of such good character as to justify the placement and not present a risk of harm to the child pursuant to paragraph (3).” [emphasis added]

The law adds the requirement for fingerprint clearance checks and FBI criminal history information as a condition for approval for placement, in addition to those items already obtained for detention as directed by WIC 309. This section specifically indicates that the fingerprint clearance check must be submitted within 10 calendar days of the CLETS request submission. That is consistent with DCFS policy and practice, contrary to the contention of the audit on page 8. The additional checks mandated by WIC 361.4 take a substantial amount of time to complete. This procedure makes sense in light of the fact that the disposition hearing must take place no later than sixty (60) days from the time of initial removal (see WIC 352(b)), thereby giving the Department the additional time to complete the full assessment.

By directing that a criminal records check be cleared pursuant to Health and Safety Code section 1522, the legislature reinforced the notion that there is a distinction between a WIC 309 detention (which is excluded from the Health and Safety Code 1522 requirements per Health and Safety 1505) and placement (which must have a license cleared pursuant to Health and Safety 1522).

⑤

Unfortunately the audit appears to focus strictly on placements occurring pursuant to WIC 361.4. DCFS policy is consistent with those requirements as well as the legal standards for temporary detention found in WIC 309. DCFS policy complies with both the letter and intent of the law.

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2.2 To improve its process for placing children with a relative, the department should analyze the best practices used by other county child welfare service agencies for such placements. The department should then implement changes in its practices so that relatives and their homes are approved prior to placement, as required by state law.

DCFS agrees in principal with this recommendation. The managers of the Policy Section and ASFA Section will request and review copies of relative placement protocols and policies from other county peers as recommended by BSA. The DCFS Executive Team will conduct an evaluation of the placement practices from these county partners with County Counsel to help determine potential improved relative placement practices. DCFS is also currently evaluating the possibility of aligning its ASFA Division operations with our 24-hour Emergency Response Command Post operation. In regards to DCFS' assertion that the Department conducts relative placements as required by law, please see response to 2.1 above.

2.3 To ensure that social workers have as much relevant information as possible when placing children and licensing homes, the department should report requisite allegations of abuse or neglect to DOJ and Social Services' licensing division.

DCFS concurs with this recommendation. This is an area in which DCFS made program and policy changes shortly after the period under review in BSA's report. DCFS has re-established a centralized investigations unit in our Out-of-Home-Care Division which works in collaboration with ER regional staff on the investigations of Foster Family Agency (FFA) certified homes. Since January 18, 2011 this unit has been assigned to all referrals of child abuse and neglect in FFA homes; concurrently or following ER investigation, social workers and managers from this unit follow up on allegations and make decisions about the continued use of certified foster homes as placement resources. This unit communicates all findings on FFA referrals to Community Care Licensing (CCL). In addition, all out-of-home care referrals are directly sent from our Child Protection Hotline and CCL completes a separate independent investigation of all licensed and certified out-of-home care providers/agencies.

DCFS has changed ER practices to ensure DOJ and CCL cross-reports are completed consistently and accurately for all referrals. ER social workers previously sent out cross-reports directly to DOJ and CCL after consultation with the supervisor on the disposition of the allegations. DCFS changed this practice and social workers now generate, print, and attach cross-reports to the folders upon submission to the supervisor for final approval and closure. The supervisor reviews the cross-report documents for accuracy and forwards them to their unit clerks for mailing. Social workers are to maintain copies of cross-reports in the referral folders upon submitting the referral for closure. We believe these practices and the strengthening of policy related to this function will result in more accurate and appropriate DOJ and CCL cross-reports. DCFS looks forward to the day when the DOJ cross-reports can be electronically generated and securely sent to DOJ with a tracking mechanism, and CWS/CMS is able to verify the DOJ report transmittal prior to allowing closure of the referral on non-general neglect allegations which are substantiated.

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2.4 To fully benefit from its death review process, the department should implement the resulting recommendations.

DCFS agrees with this recommendation and will implement death review recommendations after they have been fully vetted with Executive Team members and impacted divisional and regional managers. The Administrative Review Round Tables (ARRT) and resulting reports are part of a larger process of analysis and reporting on child fatalities. Recommendations made at an ARRT are tentative and subject to further examination as the review process continues. Consequently, some recommendations made at ARRT are confirmed and acted upon by DCFS' leadership while others may be modified and then acted upon. The two recommendations referred to in the report were ultimately modified in favor of a different course of action which DCFS has adopted. In the first instance in which the BSA found discrepancies between a recommended policy change and no specific separate policy addressing the issue, DCFS identified seven existing policies where the desired practice was required. Therefore, the recommendation was modified to address the practice related issues and not to create a separate specific policy for the intended action(s). In the second instance, DCFS discovered that existing policy was clear on the appropriate practice expectation. However, a particular incident of mis-mapping of the referral from the Emergency Response Command Post (ERCP) to the regional office did occur. While the mis-mapping was not a factor in the death of the child, DCFS' final action plan in response to the incident and initial recommendation did include the strengthening of practices at ERCP and not a policy change or new policy.

3.1 To provide effective leadership, the director should form a stable executive team by filling the department's chief deputy director, senior deputy director, and other deputy director positions.

DCFS agrees with this recommendation and the newly appointed Director has already submitted formal position openings and engaged in a nationwide search for the aforementioned executive positions.

3.2 To create and communicate its philosophy and plans, the department should complete and implement its strategic plan.

DCFS agrees with this recommendation and expects a finalized strategic plan to be finalized soon. DCFS previously conducted 88 focus groups and six larger regionalized convenings, inclusive of community stakeholders, to develop a strategic plan and had completed an initial draft plan in November 2010. However, finalization of the plan was placed on hold due to the loss of the permanent Director. During the intervening period, focus was placed on developing and implementing our Department's Data-Driven Decision Making (DCFS STATS) System, which is integral to monitoring the strategic plan, once finalized. DCFS STATS includes a data dashboard which provides staff baseline and benchmark data on key outcomes and performance indicators that will be tied to our strategic goals and initiatives. Since the newly hired Director's arrival, DCFS accelerated the implementation of DCFS STATS, and has conducted numerous formal activities to build upon the previously drafted plan and develop a new four-year plan. This new four-year strategic plan has been through several drafts and a final draft is imminent.

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE LOS ANGELES COUNTY DEPARTMENT OF CHILDREN AND FAMILY SERVICES

To provide clarity and perspective, we are commenting on the response to our audit report from the Los Angeles County Department of Children and Family Services (department). The numbers below correspond to the numbers we placed in the margin of the department's response.

While preparing our draft report for publication, page numbers shifted. Therefore, the page numbers that the department cites throughout its response do not correspond to the page numbers in our final report.

①

The department asserts its compliance with state law by simply restating state law and its own policy. The lengthy legal justification included in the department's response never actually explains how the department is in compliance with the home and caregiver assessment requirements in Welfare and Institutions Code, Section 309(d). In contrast to the department's approach, we looked for actual evidence that required home and caregiver assessments took place before asserting either compliance or noncompliance. As indicated on page 29, we found that the department's process for completing these assessments, and thereby approving relatives for placement, is not designed to be done prior to placement, as required by state law.

②

The department knows which cases we reviewed; we have been discussing and requesting information related to these cases for nearly six months. We also met and discussed our findings with the department nearly three weeks prior to its written response. The fact that it now asserts that "all 20 cases *may* be in compliance", without being able to provide evidence of compliance during the audit, is disingenuous. To refute the notion that the department may be in compliance, we provide a summary of the nine placements in our sample that were not in compliance with state requirements on the following page.

③

The department's summary of state law and its policy is inaccurate and misleading. Although we are not entirely sure of the department's intent, the inaccurate and misleading statements appear designed to suggest that the department is not "placing" children when social workers deliver detained children to the homes of relatives and nonrelated extended family members (relatives). Misquoting Welfare and Institutions Code, Section 309(d), the department wrote "If an able and willing relative . . . is available and requests temporary *detention* of the child pending the detention hearing, the county welfare agency shall initiate an assessment of the relative . . ." The italicized word is inaccurate; the statute actually uses the word "placement" rather than "detention."

④

Table
Summary of Documented Efforts to Complete Home and Caregiver Assessments, and Criminal Background Checks

| NONCOMPLIANT CASES SHOWN IN FIGURE 7 ON PAGE 27 (NUMBERED FROM TOP TO BOTTOM OF FIGURE) | DEPARTMENT ASSESSMENT AND BACKGROUND CHECK ACTIVITIES, OCCURRING: | |
|---|---|---|
| | PRIOR TO PLACEMENT | AFTER PLACEMENT |
| 1 | In case notes, a social worker briefly described visiting the home and reported that the home does not seem to meet standards and would not pass a home assessment. | As stated on pages 26–27 of the report, the court placed the child in this home in spite of Los Angeles County Department of Children and Family Services (department) recommendations. However, the department never reassessed the home as ordered by the court. The department also did not complete any criminal or Child Abuse Central Index (CACI) checks for one of the four adults in the home until 25 days after the placement. |
| 4 | The case notes do not specifically state whether a social worker visited the home prior to placement. In the first case note, dated 18 days after placement, a social worker stated she visited the relative's home for the first time. | The department did not perform home and caregiver assessments until 52 days after placement. The department completed a CACI check one day after placement. It was unable to provide evidence of ever completing a California Law Enforcement Telecommunication System check. Finally, the department did not obtain criminal history checks performed by the California Department of Justice and Federal Bureau of Investigation (LiveScan) on the two adults living in the home until 51 days after placement. |
| 5 | Case notes indicate that the relatives picked up the child from a department office. The case notes do not indicate that the department visited or assessed the home prior to placement. The department performed all requisite criminal checks for one of the two adults in the home prior to placement. | The department did not perform caregiver and home assessments until 31 days after placement. Additionally, it did not perform a CACI check on one of the adults until 31 days after placement. |
| 7 | Case notes indicate that social workers did not visit the home prior to placement. | The department did not perform a caregiver and home assessment, or background checks prior to placement. It did not complete the caregiver and home assessment, or a CACI check on any adult in the home prior to removing the child from the home, seven days after placement. |
| 12 | Case notes indicate that a social worker visited the relative's home more than six months prior to placement and noted that it appeared to be "clean and appropriate." A month prior to that visit, a different social worker stated that she conducted the initial home assessment, although no additional information about the caregiver or home is provided in the case notes. The department completed all background checks prior to placement. | The department did not perform a caregiver and home assessment using required California Department of Social Services (Social Services) assessment forms until 11 days after the placement. |
| 13 | In the case notes, a social worker noted that she inspected the home on the date of placement, although no details about the inspection are included. The department completed all background checks prior to placement for two of three adults. | The department did not perform a caregiver and home assessment using required Social Services assessment forms until 18 days after placement. The department did not complete a CACI check for one of the three adults in the home until three days after the placement. |
| 14 | A social worker visited the home a day prior to the placement. The social worker noted in his case notes that the home was clean and had child-proof locks on cabinets, no firearms, no alcohol/drug paraphernalia, and plenty of food and beds. The department completed all background checks prior to placement for two of three adults. | The department did not perform a caregiver and home assessment using the required Social Services assessment forms until eight days after placement. It did not perform its CACI check and receive LiveScan results for one of the three adults living in the home until seven and six days, respectively, after placement. |
| 19 | In the case notes, a social worker noted that she used a required Social Services assessment form and assessed the caregiver and home prior to placement. The department completed all background checks prior to placement. | Based on forms provided by the department, it did not perform and document a caregiver and home assessment using required Social Services assessment forms until 22 days after placement. |
| 20 | In the case notes, a social worker noted visiting the home 9 days prior to placement. However, she stated she could not approve the home at the time because it did not have adequate space. | The department did not perform a caregiver and home assessment using required Social Services assessment forms until 28 days after placement. It did not receive LiveScan results for one of the adults living in the home until after it already removed the child from the placement. |

Similarly, the department either misquoted or informally changed the policy quoted in its response, twice replacing the word “placement” with the word “detention.” As of March 19, 2012, the department’s policy published on its Web site still used the word placement. The department also noticeably omits any reference to its policy that allows social workers to temporarily place a child with relatives if the relatives pass a background check and they “complete the initial in-home inspection, using the SOC 817 [form] as a guide ([social workers] are not required to complete the SOC 817, it is only to be used as a guide) . . .” As we indicated in the footnote on page 26, not requiring social workers to complete and document home and caregiver assessments does not allow department management, including supervisors who must approve temporary placements, to verify whether these initial in-home inspections are being done prior to placement.

In providing its “Legal Justification” as to why it believes it is not required to perform caregiver and home assessments prior to placing children in homes, the department purports to set forth the relevant provisions of law, but has actually changed the wording of the law in an attempt to support its argument. Moreover, it has omitted relevant provisions of law that completely undermine its argument. The relevant provisions of law—those found in paragraph (4) of Welfare and Institutions Code, Section 309(d)—plainly indicate that Section 309 is not excluded from the provisions of Health and Safety Code, Section 1522, despite the department’s statements to the contrary. Therefore, the legal conclusion the department is trying to reach is fundamentally flawed.

As described in comments 4 and 5 above, the department’s summary of the differences between Welfare and Institutions Code, sections 309 and 361.4, is inaccurate and misleading. Further, throughout its legal justification, the department did not once describe how it is in compliance with the home and caregiver assessments required by Welfare and Institutions Code, Section 309(d). As indicated in the footnote on page 26, the department management cannot know or demonstrate that these assessments are occurring because it requires no documentation of them. The department’s distinction between “detaining” and “placing” children with relatives makes little difference to the children placed in these homes. Their safety is dependent on the department’s efforts to ensure that these homes and caregivers are safe. We stand by our recommendation that the department revise its process to conduct required assessments prior to placement.

The department misunderstands. The department wrongly equates the nearly 900 placements described on page 29 to removals of children from placements. In fact, the department’s own home assessment unit found that nearly 900 of these placements did not meet standards. We used the term “unsafe and inappropriate” to

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⑦

account for the variety of situations for which the home assessment unit denied approval of a placement. These circumstances can range from a caregiver with a criminal record (unsafe placement), to a caregiver who is unwilling or unable to provide for the educational needs of a child (inappropriate placement). As we note on page 29, after the department's home assessment unit made its determination that a placement was unsafe or inappropriate, the department typically took 43 days to either remove the children or reassess and approve the homes.

- ⑧ The California Department of Social Services (Social Services) may have approved the waiver in the faith that the safety and service enhancements were credible but, as we note on page 17, the department did not faithfully carry out the agreements of the waiver. In fact, although the waiver was effective in July 2010, the department did not even notify social workers of the additional contact requirements specified in the waiver until February 2011.
- ⑨ As discussed on pages 18 through 20, according to various current and former department officials, the improvement in the timeliness of investigations was the result of increased resources devoted to investigations and revisions to ill-advised policies. The waiver allowing the department to close investigations within 60 days, instead of 30 days, did nothing to decrease the backlog of uncompleted investigations. It only changed the definition of what the department considered to be uncompleted investigations.
- ⑩ We are unsure what the department means by "quality." Timeliness is certainly one aspect of quality and the department's information shows that the timeliness of its investigations in 2009 was much better than in 2010 (see Table 2 on page 15; Figure 4 on page 18). Despite reductions in timeliness, the department experienced no recognizable difference in the percentage of allegations that it deemed substantiated, inconclusive, or unfounded. If other aspects of the quality of its investigations had changed, we would expect to see a noticeable difference in these percentages—inconclusive investigations in particular.
- ⑪ The department neglects to state that the Child Welfare Services/ Case Management System (CWS/CMS) already includes a field where social workers record whether or not they submitted a report to the California Department of Justice (DOJ). In addition to the department not being able to provide these reports to us, CWS/CMS indicated that a report to DOJ was not made in all five of the cases described on page 34 of the report.
- ⑫ As denoted by the term "generally," the sentence is not intended to be a complete list of everything the department does. Family reunification services are described Figure 1 on page 6.

The language, as written, is sufficiently clear and accurate; we did not make a change.

⑬

A complete summary of events and statements made during the county's refusal to grant us access to documents would be lengthy and, at this point, unnecessary. We believe what we have written suffices.

⑭

The department may have been seeking open communication and agreed upon solutions, but once it received the 60-day waiver, it did not attempt to carry out the agreement's provisions until more than seven months later.

⑮

We depict the number of investigations not completed within 30 and 60 days in Figure 4 on page 18. We are well aware that Social Services is the only entity that can rescind the temporary 60-day waiver. However, for us to write about the backlog of investigations using only 60 days as the measure would be inconsistent with our recommendation on page 23.

⑯

Social Services' regulations state that in-person investigations are to occur either immediately or within 10 days, depending on the nature of the allegations. The regulations make no mention of "attempted contacts" as an acceptable response. As we indicate in comment 18 below, we believe measuring visits actually completed is appropriate.

⑰

We realize the department does not control whether or not a family is at home; however, it does control when and how it attempts contact. Using visits actually completed as a performance measure may spur the department to be more creative and effective in its attempts to complete in-person contacts, which the department agrees "is the key ingredient in a successful assessment of a child's safety."

⑱

We explain our testing rationale in a footnote on page 17 of the report. Furthermore, if the department had actually tried to implement the additional contacts required by the 60-day waiver sooner, it would not have taken nearly a year and half to discover and resolve this misunderstanding.

⑲

April 2011 was the date previously provided by the department; however, because the department now feels strongly that the correct date is April 2010, we made the appropriate changes in the report. We conducted numerous interviews during the audit asking department officials to identify the policies that significantly affected the backlog of investigations. These officials did not indicate that these other protocol enhancements had a significant effect on the backlog.

⑳

- ⑳ The department is required to perform home and caregiver assessments under both statutes cited. Welfare and Institutions Code, Section 309(d), clearly states that these assessments are to occur prior to placement. As noted earlier, the department—in addition to modifying terms in its recitation of state law and its policies—is careful not to state that it is relying on undocumented assessments to support its assertions that it complies with state law. As we indicate in the footnote on page 26, we tested compliance using documented assessments as required by Social Services.
- ㉑ A mandatory and defined field in CWS/CMS identifies emergency placements. It would be impossible for us to review individual detention reports for thousands of placements, as suggested by the department. Even if the vast majority of placements are done on an emergency basis, as asserted by the department, the department’s assessment process is not currently designed to complete required home and caregiver assessments prior to these placements, as required by state law.
- ㉒ The department again indicates that the undocumented assessments that it presumes are being conducted prior to placement negate all findings related to the timeliness of the department’s documented assessments. We disagree.
- ㉓ The department is incorrect. The referenced All County Letter never states that home and caregiver assessments can be completed after placement. The 30-day time frame alluded to by the department relates to the number of days the department has to assess a home from when relatives request placement of children in their homes. The original 05-13 All County Letter, which the “Errata” (or change) letter only clarifies in a few instances, specifically mentions Social Services’ required assessment forms and states that all standards must be met prior to placement. The change letter only adds that a child may be temporarily placed in a home that is under a corrective action plan for certain, less serious deficiencies. Given that a corrective plan would only follow a formal assessment, the change letter clearly implies that all caregivers and homes must be formally assessed prior to placement—something the department’s assessment process is not designed to do. Further, neither the original nor the change letter ever mentions the distinction between detention and placement that the department has conjured from its misleading, inaccurate, and prejudicially selected quotations of state law and its policy.

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