



## Child Welfare Services

The County Child Welfare Services Agencies We Reviewed Must Provide Better Protection for Abused and Neglected Children

Report 2013-110

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April 8, 2014

2013-110

The Governor of California  
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State Capitol  
Sacramento, California 95814

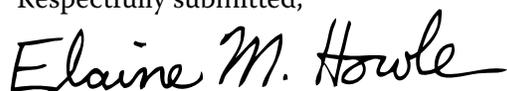
Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the policies and procedures the child welfare services (CWS) agencies of Butte, Orange, and San Francisco counties follow when considering whether to remove children from their homes. This report concludes that these agencies must provide better protection for abused and neglected children. Specifically, although all three agencies require the use of standardized safety and risk assessments, the agencies' social workers frequently did not prepare these assessments in a timely manner or at all, and the information used in these assessments was often inaccurate. This led to flawed evaluations of safety, risk, and needed services and, at times, led to poor decisions related to child safety. Additionally, when their initial attempts to make in-person contact with children to investigate reports of child maltreatment were unsuccessful, social workers did not consistently follow up in a reasonable time frame—sometimes waiting weeks before attempting to see the child again. Further, when social workers decided to leave a child in a home that presented a safety threat, they often did not establish a credible safety plan to mitigate that threat. In addition, social workers at times allowed the child to be placed or remain in a temporary living situation without performing any history check on the temporary caregivers and, in a few instances, these individuals were later found to be unfit to supervise the child. When the county CWS agencies we visited did formally remove a child, they did not always perform required background checks before a subsequent placement.

State laws and regulations provide county CWS agencies with broad discretion in determining when to involve law enforcement in investigations and in removing children from their homes. As such, we noted that the three CWS agencies we visited have adopted divergent approaches to coordinating with law enforcement. Although each county's practices reflect the flexibility given to CWS agencies, we found instances where coordination and communication between local law enforcement and the county CWS agencies could have been better.

To varying degrees, each of the three county CWS agencies we visited needs to improve its practices. Even so, for most of the items we reviewed, the Orange County CWS agency appeared to perform better than the other two CWS agencies, and had better management processes. Given the relationship we observed between the strength of management processes and county CWS agencies' performance, we believe the California Department of Social Services—as the state agency responsible for overseeing the CWS system—should encourage and monitor the establishment of the key management processes of policy development and quality assurance at all 58 counties.

Respectfully submitted,



ELAINE M. HOWLE, CPA  
State Auditor

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# Contents

Summary	1
Introduction	5
<b>Chapter 1</b>	
Inconsistent and Inaccurate Investigative Assessments at Times Led to Poor Decisions Related to Child Safety	17
Recommendations	42
<b>Chapter 2</b>	
The County Child Welfare Services Agencies We Visited Could Improve Their Coordination With Local Law Enforcement and Their Implementation of Quality Control Processes	45
Recommendations	62
<b>Appendix</b>	
Child Welfare Services Expenditures for Butte, Orange, and San Francisco Child Welfare Services Agencies	65
<b>Responses to the Audit</b>	
California Department of Social Services	71
California State Auditor's Comment on the Response From the California Department of Social Services	75
Butte County Department of Employment and Social Services	77
California State Auditor's Comment on the Response From the Butte County Department of Employment and Social Services	83
Orange County Social Services Agency	85
California State Auditor's Comment on the Response From the Orange County Social Services Agency	93
City and County of San Francisco Human Services Agency	95

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## Summary

### Results in Brief

The three county child welfare services (CWS) agencies that we visited are not adequately ensuring that their decisions to remove or not remove children from homes are appropriate. Although the California Department of Social Services (Social Services) provides oversight of the CWS system, county CWS agencies administer the programs that are designed to protect children from ongoing abuse and neglect. When necessary for the protection of a child, county CWS agencies may remove a child from the home and place the child with relatives or in foster care. Before a CWS agency takes this step, state law and regulations require that it make efforts to keep the family together when services and other support make it safe to do so.

When a report of child maltreatment (referral) is received, county CWS agencies must determine how to respond. We visited the CWS agencies in Butte, Orange, and San Francisco counties and found that information contained in the initial intake documents was often inaccurate or incomplete. Although most of these errors ultimately proved inconsequential, a few ended up affecting decisions regarding the appropriate response to a referral. The three county CWS agencies have each adopted the use of standardized assessments that analyze safety and risk factors of families for which the agencies have received a referral, and the agencies also examine what services a family may need to allow the child to safely remain in or return to the home. Although these assessments are the principal mechanism by which these agencies document critical decisions regarding the child's safety, we found that some assessments were not prepared in a timely manner or were not prepared at all. We also found that the information used in these assessments was often incomplete and inconsistent. At times, this led to flawed evaluations of safety, risk, and needed services. Although we found a few instances where safety threats identified in assessments had no documented basis, most of the errors we found involved social workers leaving out key safety threats from assessments, which can lead to leaving children in unsafe situations.

When their initial attempts to make in-person contact with children and parents to investigate allegations of child maltreatment were unsuccessful, the county CWS agencies we visited did not consistently follow up in a reasonable time frame—sometimes waiting weeks before attempting to see the child again. Further, when social workers decided to leave a child in a home that presented a safety threat, they often did not establish a credible safety plan to mitigate that threat. In addition, social workers at times allowed the child to be placed or remain in a temporary

### Audit Highlights . . .

*Our audit of child welfare services (CWS) agencies in Butte, Orange, and San Francisco counties highlighted the following:*

- » *Information contained in the initial intake documents prepared when reports of child maltreatment are received, was often inaccurate or incomplete.*
- » *Assessments that analyze safety and risk factors were sometimes not prepared in a timely manner or were not prepared at all.*
- » *The county CWS agencies did not consistently follow up, in a reasonable time frame, on unsuccessful attempts to make in-person contact with children—sometimes waiting weeks before attempting to make contact.*
- » *When social workers decided to leave a child in a home that presented a safety threat, they often did not establish a credible safety plan to mitigate that threat.*
- » *Social workers at times allowed the child to be placed or remain in a temporary living situation and often did not perform any history check on the temporary caregivers.*
- » *Required assessments used to determine the strengths and needs of a family, and to develop the corresponding case plan, were not always completed.*
- » *For each item we reviewed, we noted a frequent lack of documented supervisory review.*

living situation until safety concerns could be alleviated. In these instances, they often did not perform any history check on the temporary caregivers and, in a few instances, these individuals were later found to be unfit to supervise the child. When the county CWS agencies we visited did formally remove a child, they did not consistently perform required background checks before a subsequent placement.

We also found that required assessments used to determine the strengths and needs of a family, and to develop the corresponding case plan, were not always completed. In addition, assessments used to determine whether a child could be reunited with his or her family were frequently not performed in a timely manner and were sometimes not performed at all. Failing to complete this assessment could lead to social workers improperly assessing the potential danger of a child returning to the home, while late assessments indicate a child could be spending longer in out-of-home placement than necessary.

For each item we reviewed, we noted a frequent lack of documented supervisory review. For those instances when reviews were documented, it appeared at times that supervisory review occurred so late that it had little or no effect on the safety or risk decision. For instance, we found that approximately one-fourth of all safety and risk assessments received no supervisory review within 30 days of the completion of the assessment.

State laws and regulations provide county CWS agencies with broad discretion in determining when to involve law enforcement in investigations and in removing children from their homes. Their policies and practices regarding involvement of law enforcement in CWS efforts reflect this flexibility. Even so, we found instances where coordination and communication between local law enforcement and the county CWS agencies we visited could have been better.

To varying degrees, each of the three county CWS agencies we visited needs to improve its practices, as any deficiency in these practices increases the likelihood that a child will suffer further abuse and neglect. Even so, for most of the items we reviewed, the Orange County CWS agency, which was one of the earliest adopters of standardized assessments, appeared to perform better than the other two CWS agencies. Although all three aspire to models considered to encompass best practices in California, the Orange County CWS agency appears to have better developed its management processes designed to ensure compliance with requirements. In particular, for a number of years it has maintained designated policy development and quality assurance units that help provide clear communication to staff and ongoing feedback

to management. The Butte County CWS agency recently developed a one-person quality assurance function, but neither this agency nor the San Francisco County CWS agency has personnel designated to update policies and procedures. Given the relationship we observed between the strength of management processes and county CWS agencies' performance, we believe Social Services—as the state agency responsible for overseeing the CWS system—should encourage and monitor, for a time, the establishment of the key management processes of policy development and quality assurance at all 58 counties.

### Recommendations

To ensure that all required assessments are completed, the CWS agencies of Butte and San Francisco counties should develop and implement clear guidance regarding which assessments are required in different situations.

To improve the timeliness and accuracy of all required assessments, the CWS agencies of Butte, Orange, and San Francisco counties should ensure that their supervisors are reviewing assessments in a timely manner.

The CWS agencies of Butte, Orange, and San Francisco counties should ensure that social workers are making reasonable and timely efforts to make in-person contact with children who are allegedly being maltreated.

To help strengthen safety plans to effectively mitigate safety threats, the CWS agencies of Butte, Orange, and San Francisco counties should ensure that supervisors are reviewing and approving all safety plans.

To improve the timeliness of their supervisors' reviews:

- The CWS agencies of Butte and San Francisco counties should develop time frames for supervisors' review and approval of assessments, and monitor supervisors' compliance with those time frames.
- The CWS agency of Orange County should more closely monitor supervisors' compliance with its existing policy setting a 30-day time frame for review and approval of assessments.

To ensure that required safety plans are created, the CWS agencies of Butte, Orange, and San Francisco counties should have supervisors promptly review all safety assessments and verify that a written safety plan the responsible parties have signed accompanies any assessments designating the need for such a safety plan.

As part of their responsibility to help children remain safe at all points during the investigation of a referral, the CWS agencies of Butte, Orange, and San Francisco counties should do the following:

- Vet temporary living situations and caregivers to the extent allowable under the law, including a review of information contained within the statewide CWS database.
- Perform statutorily required background checks and inspections before allowing children to be placed in a home.

To ensure that they provide clear, up-to-date guidance to their social workers, the CWS agencies of Butte and San Francisco counties should designate specific personnel to stay informed of relevant practice changes and to ensure that corresponding updates are made to their policies and procedures.

To promote continued improvement in the CWS system, Social Services should encourage each county CWS agency to designate personnel to regularly update policies and procedures and perform quality assurance reviews. Further, Social Services should monitor the status of each county CWS agency's efforts.

### **Agency Comments**

Social Services and the three county CWS agencies we reviewed agreed with our findings and recommendations. Each outlined actions it plans to take in response to the recommendations.

# Introduction

## Background

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

California CWS agencies received 482,000 allegations of maltreatment of children in 2013. They substantiated 81,000 of these allegations through their investigative efforts and removed more than 31,000 children from their homes as a result of the investigations.<sup>1</sup> According to Social Services' estimates, California's systemwide child welfare budget from federal, state, and county funding sources was approximately \$5.4 billion in fiscal year 2012–13.

## Roles of Entities Involved in CWS

California's Welfare and Institutions Code requires that the State, through Social Services and county welfare departments, establish and support a CWS system. California uses a state-supervised, county-administered model of CWS governance. Under this model, each of California's 58 counties establishes and maintains its own program, and Social Services monitors and provides support to counties through oversight, administrative services, and development of program policies and regulations. State law requires both county CWS agencies and local law enforcement (which may share information) to receive and investigate allegations of child abuse or neglect and make immediate decisions about whether a child is safe to remain in the home or must be temporarily removed. When CWS removes a child from the home, the CWS agency must file a petition within 48 hours with the county juvenile court

<sup>1</sup> The source of this information is unaudited data from CWS reports retrieved from the University of California at Berkeley, Center for Social Services Research Web site. Of the allegations that were not substantiated, 193,000 were unfounded, 89,000 were inconclusive, 104,000 received an initial assessment but did not warrant an investigation, and 15,000 had not yet been determined as of December 2013.

detailing facts regarding the child. The juvenile court subsequently hears the facts surrounding the removal and decides on the best course of action for the child.

### ***The Role of Social Services***

Social Services—through its Children and Family Services Division—is responsible for providing oversight of the State’s CWS system. Social Services also receives and distributes federal and state funding that provides support for county CWS agencies and ensures that counties provide matching funds at specified levels. Additionally, Social Services oversees operation of the statewide automated Child Welfare Services/Case Management System, which agencies use to manage and document their case management activities. Further, Social Services monitors county CWS programs through an outcome-based quality assurance system called the California Child and Family Services Review. This review uses a continuous five-year cycle of peer reviews, self-assessments, and improvement plans to assess, monitor, and track county CWS agency performance. Finally, Social Services’ Community Care Licensing Division provides oversight and regulatory enforcement for licensed community care facilities statewide, including licensing foster and group homes that house children removed from unsafe homes.

### ***The Role of County CWS Agencies***

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

- **Emergency response:** In-person, 24-hour response to reports of child abuse, neglect, and exploitation, with the purpose of maintaining the child safely in the home or protecting the child’s safety through emergency removal and foster care placement.
- **Family maintenance:** Time-limited services designed to prevent or remedy neglect, abuse, and exploitation in an attempt to avoid separating children from their families.
- **Family reunification:** Time-limited services designed to reunite children with their families subsequent to their removal for safety reasons.

- **Permanent placement:** Services designed to ensure that children who have been removed from their families find new safe, stable, and permanent homes.

In the short term, county CWS agencies have the responsibility to make decisions regarding the type and duration of services provided to an individual child or family, but juvenile dependency courts ultimately make decisions regarding the long-term needs of dependent children in the CWS system. State law generally requires county CWS agencies to leave children in their homes whenever it is safe to do so. To this end, state regulations require county CWS agencies, when initially investigating allegations of child maltreatment, to determine whether safety or other risks exist for a child in his or her home. When a CWS agency identifies safety risks, it attempts to mitigate those risks with interventions developed with the family and documented in a safety plan. Safety plans contain interventions such as connecting families with community services, obtaining restraining orders, or having a nonoffending parent move with the child to a safe location, such as a domestic violence shelter or relative's home. These efforts are intended to keep the child with his or her family when possible and appropriate.

### ***The Role of the Courts***

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

### **The CWS Process**

Although variations exist, the typical CWS process begins when a mandated reporter (see the text box) or a concerned individual calls in a report of child maltreatment (referral) to a county child abuse hotline. A social worker screens the call, assesses the risk to the child, and decides whether the referral should be evaluated out (no further action is taken) or whether an in-person investigation must be conducted immediately or within a 10-day period.

#### **Mandated Reporters**

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

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

Source: California Penal Code, sections 11165.7 and 11166.

Referrals from law enforcement must be investigated in person and cannot be evaluated out unless law enforcement has already investigated and determined that there is no indication of abuse or neglect.

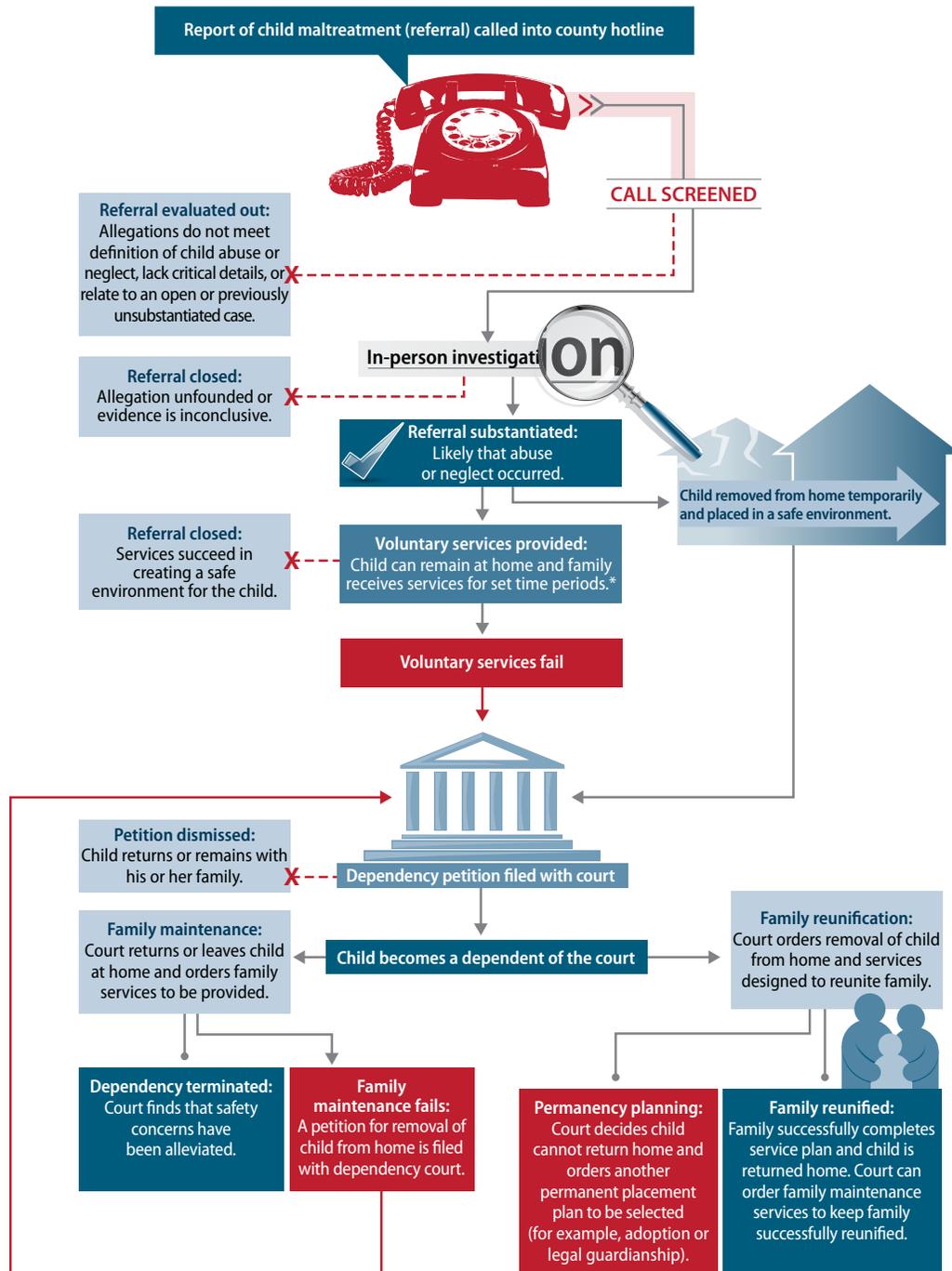
State law requires an immediate in-person investigation in all situations in which a child is in imminent danger of physical pain, injury, disability, severe emotional harm, or death. Although county policies for response times vary, when a referral requires an immediate in-person investigation, it typically must occur within two to 24 hours. State law requires an in-person investigation within 10 days when a child is not in imminent danger (for example, when the child is in a safe place, such as a hospital or a relative's home where the perpetrator no longer has access to the child).

If a CWS agency determines through its investigation that an allegation of abuse or neglect is unfounded, or if the evidence is inconclusive, it may close the referral. As indicated in Figure 1, once a referral is substantiated, the child may either remain at home while voluntary services are provided or be removed temporarily from the home by the social worker or law enforcement officer and placed in a safe environment. Within 30 calendar days of the initial removal of the child, of the in-person investigation, or of the date of a juvenile court hearing, whichever comes first, the CWS agency must determine whether continued services are necessary and, if so, begin a corresponding case plan.

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

When a court declares a child a *dependent child*, it may allow the child to remain at home, ordering family maintenance services and potentially limiting the control the child's parent or guardian exercises. Alternatively, the court may order that a dependent child be removed from the custody of the parent or guardian, in which case state law requires the court to first consider placing the child with a parent who did not have custody when the abuse or neglect occurred. If a noncustodial parent is not an option, the court will order that the child's care, custody, control, and conduct be under the supervision of the county CWS agency. A social worker may

**Figure 1**  
Major Components and Processes of the Child Welfare System



Sources: California Welfare and Institutions Code; California 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.

place that dependent child, in order of priority, with relatives or in a foster home or other suitable community care facility such as a group home. In both of these situations, the social worker and the family jointly develop a case plan to meet the needs of the family and address the safety concerns about the home environment.

The CWS agency must provide permanent placement services for children who cannot safely live with their parents and who 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. Reunification of children with their families is a priority until the court decides that it is not in the children's best interest, which then allows them to be adopted by parents that Social Services or the county CWS agency has recruited.

### **State Efforts to Identify and Implement Best Practices for the Protection of Children**

In 2000, Assembly Bill 1740 (Chapter 52, Statutes of 2000) authorized the establishment of an advisory group of CWS stakeholders, eventually comprising more than 60 members, to review the State's CWS system and make recommendations for improvement. In 2003 the stakeholders group published its final report, referred to as the *Child Welfare Services Redesign*. That same year, Social Services launched an 11-county pilot project, based largely on the system improvements that the stakeholders group recommended. In March 2010 Social Services published a report evaluating the pilot project. The report indicated that child welfare workers and community partners found the following strategies to be best practices:

- **Standardized Safety Assessment:** A set of tools that assist social workers in gathering and evaluating information, deciding how to respond, and determining whether children are safe in their current living situation or whether an alternative living arrangement is appropriate.
- **Differential Response:** A strategy that allows social workers to respond in a flexible manner to reports of child abuse or neglect by, for example, providing services and support to families whose levels of risk and safety would traditionally not have required a CWS intervention.
- **Permanency and Youth Transition:** A strategy that involves parents, children, and others, such as extended family members, foster families, and other interested parties, in making decisions

regarding the safety of the child. This includes attempts to find members of the child's family with whom the abused or neglected child might be placed.

### **Standardized Safety Assessments**

Standardized Safety Assessments are now a part of all the critical decisions California county CWS agencies must make regarding the safety and well-being of children. They consist of a comprehensive set of tools and assessments that assist social workers in making decisions throughout child maltreatment cases, including whether children are safe in their current living situation and whether factors exist that place the children at risk of being abused or neglected. Social Services encourages county CWS agencies to use one of two available Standardized Safety Assessment methodologies: Structured Decision Making (SDM) or the Comprehensive Assessment Tool (CAT).<sup>2</sup>

The policies of each of the counties we visited require the use of SDM. According to Social Services, SDM promotes a consistent practice of assessing children's safety; helps ensure consistency in service delivery throughout the State; and provides specific, written documentation of the review, evaluation, and decisions made in a case. In Chapter 1 we provide a detailed review of how consistently and accurately the three county CWS agencies adhered to the tenets of SDM. The components of SDM, including when each tool or assessment should be used, are listed in Table 1 on the following page.

### **Funding for CWS**

Funding for CWS is a combination of federal, state, and county resources. As indicated in Figure 2 on page 13, systemwide funding has generally remained steady for the last several fiscal years. The figure depicts the primary funding sources for the State's child welfare system, including allocations for the four key services discussed earlier as well as foster care and adoption programs.

<sup>2</sup> Social Services indicated that 54 counties use SDM, while four counties use CAT.

**Table 1**  
**Description of Structured Decision Making Tools and Assessments**

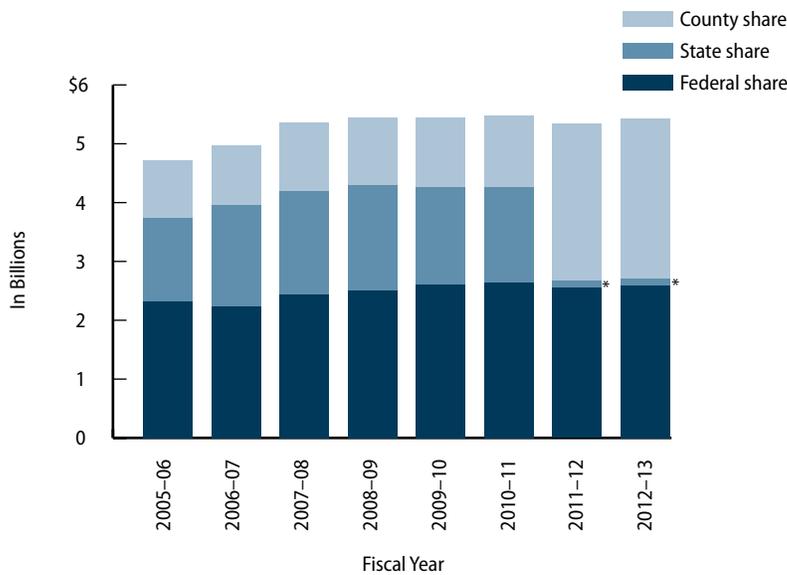
STRUCTURED DECISION MAKING TOOL OR ASSESSMENT	WHEN IS IT USED IN THE CHILD WELFARE SERVICES (CWS) PROCESS?	WHICH CWS DECISIONS DOES IT INFORM?	BY WHEN IS CWS REQUIRED TO COMPLETE IT?
Hotline tool	When a CWS agency receives a report of child maltreatment (referral).	Whether an in-person response is necessary and, if so, whether CWS should respond immediately or within 10 days.	Immediately upon receipt of a referral.
Safety assessment	When a CWS worker is conducting an in-person investigation of a referral, before leaving a child in the home.	Whether the child may safely remain in the home with or without safety interventions, or whether the child must be removed from the home.	During the investigation, before leaving a child in the home; the form itself should be completed within two working days of the first CWS contact.
Risk assessment	After a CWS worker conducts an in-person investigation, but before the referral is closed or is opened as a case.	Whether the risk of future maltreatment is enough to warrant opening a case and preparing a case plan.	No later than 30 days from the first face-to-face contact with the child.
Family strengths and needs assessment	When planning service interventions for CWS case plans.	Which family needs should be addressed in the case plan.	Before creating a case plan.
Reunification assessment	At the start of a review of a CWS case involving children in placement with a goal of being reunified with their families.	Whether to return a child to a home, maintain out-of-home placement, and/or terminate reunification services and implement a permanency alternative.	Within six months of the county providing reunification services, and at least once every six months thereafter.

Source: Children's Research Center, *The Structured Decision Making System: Policy and Procedures Manual*.

Historically, the State's share of CWS funding has been paid primarily out of the State's General Fund. However, as shown in the figure, as part of a new law called the 2011 Realignment (realignment), beginning in fiscal year 2011–12, a portion of state sales and use tax revenues and vehicle license fee revenues are now designated for the counties and deposited into a separate account within the State's Local Revenue Fund 2011 to support various CWS activities. The Legislative Analyst's Office reported that realignment did not change major functions of the CWS system. Rather, it transferred most nonfederal funding responsibility for child welfare programs to the counties. Before realignment, when CWS caseloads increased, the State and counties would share in these increased costs. Counties now bear the primary financial

responsibility for increased caseloads, thereby placing greater financial pressure on the counties to contain child welfare system costs. In the Appendix we provide specific expenditure information for the three county CWS agencies we reviewed during the audit: Butte County, Orange County, and San Francisco County.

**Figure 2**  
**Child Welfare Services Budget**  
**Fiscal Years 2005–06 Through 2012–13**



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

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

\* As a result of a new law called the 2011 Realignment, most of the funds previously designated as state share are now included in the county share shown in the figure.

**Scope and Methodology**

The Joint Legislative Audit Committee (audit committee) directed the California State Auditor to examine the practices of three selected county CWS agencies related to the removal of children from their homes. The analysis the audit committee approved contained seven separate objectives. Table 2 beginning on the following page lists the audit committee’s objectives and the methods we used to address those objectives.

**Table 2**  
**Audit Objectives and the Methods Used to Address Them**

AUDIT OBJECTIVE	METHOD
1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.	We reviewed relevant laws, rules, regulations, and other background materials.
2 Determine and assess the policies, procedures, and processes county child welfare services (CWS) agencies follow for removing a child, including the following: a. Handling of complaints and investigations.	<ul style="list-style-type: none"> <li>• We reviewed the policies and procedures of the three county CWS agencies we visited.</li> <li>• We used a data extract of the Child Welfare Services/Case Management System (statewide case management system) provided to us by the California Department of Social Services (Social Services) to randomly select 120 total referrals (40 at each of the three agencies) to determine whether social workers followed state laws and regulations and local policies and procedures. Of the 40 referrals at each county, 20 were selected because they resulted in a child's removal, while the remaining 20 all had a subsequent substantiated referral within six months.</li> <li>• Because we used the statewide case management system only for sample selection, we determined that a data reliability assessment was not required. Rather, we determined that it was necessary to perform data-set verification procedures and to verify the completeness of the population from which we selected referrals in Butte County, Orange County, and San Francisco County that were received from April 1, 2010, through March 31, 2013.* For the purposes of this audit, we found the data from which we extracted our sample to be complete for each reviewed county.</li> </ul>
b. Evidentiary requirements.	We reviewed relevant state laws and regulations regarding the level of evidence necessary to remove a child from his or her home and substantiate an allegation of child abuse or neglect. In instances when a referral resulted in court hearings, we reviewed the associated court findings document to see whether the county CWS agencies met the evidentiary requirements.
c. Oversight structure and decision-making authority.	<ul style="list-style-type: none"> <li>• We verified what type of assessments the county CWS agencies perform before removing a child from the home.</li> <li>• Because each of the three county CWS agencies has implemented an assessment model called Structured Decision Making (SDM), we examined the requirements of this model.</li> <li>• We examined 120 total referrals to determine the level of supervisory oversight exercised over SDM assessments and other components of the investigatory and decision-making processes, such as investigative narratives and case notes.</li> </ul>
d. Process for returning children to their parents.	For 120 total referrals, we examined the extent to which the three county CWS agencies performed strengths and needs assessments, created and implemented case plans, and completed reunification assessments.
3 Determine how county CWS agencies determine the severity of risk to the child and, once determined, what actions the agencies are required to take.	<ul style="list-style-type: none"> <li>• As indicated in item 2c, each of the three county CWS agencies we visited uses SDM to determine the risk to a child and to guide subsequent actions.</li> <li>• For a total of 120 referrals, we examined the extent to which these three agencies used SDM tools appropriately. In particular, we examined whether the information used in these assessments accurately reflected information known to the agency at the time of the assessment.</li> </ul>
4 To the extent possible, determine county CWS agencies' and law enforcement's expenditure of state and federal funds for various actions, including removing children from their homes.	<ul style="list-style-type: none"> <li>• To determine county CWS agencies' expenditures of state and federal funds, we obtained expenditure information from Social Services and matched those figures to expenditure records from county expense claims we received from the three counties. CWS agencies do not separately track the cost of removing children from their homes. These costs are included within the emergency response category.</li> <li>• To determine law enforcement's expenditures of state and federal funds, we contacted representatives from the largest law enforcement agencies in the respective counties. In all three counties, we were informed that law enforcement agencies do not track expenditures of state and federal funds for the related actions, including the removal of children. Therefore, we were unable to obtain law enforcement's expenditure information.</li> </ul>

AUDIT OBJECTIVE	METHOD
<p>5 Identify whether best practices exist for determining the protection of children and coordinating with law enforcement.</p>	<ul style="list-style-type: none"> <li>• To identify best practices, we researched recent improvement plans related to California's CWS system. We also interviewed key staff at Social Services and at each of the three CWS agencies we visited.</li> <li>• To identify whether best practices exist for coordinating with law enforcement, we interviewed key staff at Social Services and at each of the three CWS agencies we visited. We also reviewed county CWS agencies' policies and procedures for involving law enforcement, and reviewed any applicable cooperative agreements with local law enforcement at the three counties we visited.</li> </ul>
<p>6 Ascertain the protocols county CWS agencies follow for determining when to use law enforcement, including the removal of children from their homes, and identify any procedures CWS agencies use in coordinating with law enforcement when making in-person visits.</p>	<ul style="list-style-type: none"> <li>• We reviewed state laws and regulations, and CWS agency policies and practices regarding the involvement of law enforcement.</li> <li>• We evaluated the extent of law enforcement involvement in a total of 120 CWS investigations (40 at each of the three agencies).</li> <li>• We also identified whether the CWS agencies had formalized cooperative agreements with local law enforcement.</li> </ul>
<p>7 Review and assess any other issues that are significant to CWS agencies' processes for removing children from their homes.</p>	<ul style="list-style-type: none"> <li>• For each county CWS agency we visited, we identified internal controls used to ensure that the agency's objectives were met, including the implementation of policies and procedures related to receiving and investigating allegations of child maltreatment, assessing the immediate safety and ongoing risks to children, and making decisions to either remove children from their homes or allow them to remain with their families.</li> <li>• We also examined how management within these agencies monitored how well their personnel carry out policies and procedures.</li> </ul>

Sources: California State Auditor's analysis of Joint Legislative Audit Committee audit request 2013-110, and information and documentation identified in the table column titled *Method*.

\* To test the completeness of each county's referrals, we haphazardly selected 29 referrals and traced them from hard copy files back to the electronic database.

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# Chapter 1

## INCONSISTENT AND INACCURATE INVESTIGATIVE ASSESSMENTS AT TIMES LED TO POOR DECISIONS RELATED TO CHILD SAFETY

### Chapter Summary

When receiving allegations of child maltreatment, the child welfare services (CWS) agencies at the three counties we reviewed completed intake tools that often omitted key details or contained contradictory information, contributing to social workers' flawed decisions about how quickly the agency should respond. In responding to the maltreatment allegations, the social workers generally attempted to contact the alleged victims in accordance with state laws and regulations, but they were not always successful in making initial contact and did not always follow up on unsuccessful contacts in a timely manner. Further, assessments social workers made during their investigations frequently contained inaccurate information that in some instances led to incorrect conclusions. When social workers decided to leave children in a home that presented safety threats, they often did not establish a credible safety plan to mitigate those threats. Additionally, agencies may be allowing children to be placed or to remain in risky living situations outside of their homes by not vetting alternative caregivers (suggested by the parents) and by not performing background checks before formal placements with relatives or family friends. Finally, the agencies sometimes did not appropriately use assessments designed to guide them in determining what services a family needed and whether parents were ready to reunite with their children, risking that reunification could place children at future risk.

Table 3 on the following page summarizes our assessment of the completion, timeliness, and accuracy of the Structured Decision Making (SDM) tools and assessments the three county CWS agencies used at different points in the child welfare process, from the initial allegation through the investigation and—when applicable—removal and reunification. As indicated in the table, although the Orange County CWS agency was more consistent in completing these tools and assessments than the other two agencies, each county CWS agency we reviewed—including Orange County—needs at least some improvement in aspects of their use. The remainder of this chapter details these results and describes their impact on child safety.

**Table 3**  
Summary of the Use of Structured Decision Making Tools and Assessments by the Three County Child Welfare Services Agencies

STRUCTURED DECISION MAKING (SDM) DOCUMENT	RESULTS OF OUR REVIEW OF SELECTION OF 40 REFERRALS	COUNTY CHILD WELFARE SERVICES (CWS) AGENCY		
		BUTTE	ORANGE	SAN FRANCISCO
Hotline tool	Completed	88%	95%	100%
	Timely (same day as referral reported)	80	100	90
	Substantially accurate	90	93	98
Safety assessment	Completed	85%	100%	90%
	Timely (within two days of initial contact)	59	75	92
	Substantially accurate	91	95	78
	Supervisor oversight (within one month)	62	78	75
Safety plan*	Completed	31%	86%	40%
	Credibly mitigates safety risks	100	74	75
	Supervisor oversight (within one month)	25	37	25
Risk assessment	Completed	74%	100%	88%
	Timely (within 30 days of initial contact)	92	93	83
	Substantially accurate	77	68	43
	Supervisor oversight (within one month)	73	73	73
Family strengths and needs assessment	Completed	53%	97%	97%
	Timely (prior to initial case plan)	70	72	68
	Substantially accurate	90	86	76
Reunification assessment	Completed	83%	95%	92%
	Timely (within six months of the disposition hearing and every six months thereafter)	70	81	64

Source: California State Auditor's review of 40 referrals each at the CWS agencies for Butte, Orange, and San Francisco counties.

\* A safety plan is not a specific form or tool within the SDM model but is required when a safety assessment identifies safety concerns that must be mitigated.

<span style="color: green;">■</span>	96 to 100 percent
<span style="color: lightgreen;">■</span>	90 to 95 percent
<span style="color: yellow;">■</span>	80 to 89 percent
<span style="color: orange;">■</span>	70 to 79 percent
<span style="color: red;">■</span>	0 to 69 percent

### Incomplete and Inconsistent Information in Initial Intake Documents May Impede Emergency Response Actions

At the three county CWS agencies, information contained in initial intake documents prepared when a report of child maltreatment (referral) is received was sometimes inaccurate or incomplete. While many of these errors were ultimately inconsequential, some ended up affecting either decisions on the appropriate response to a referral or the CWS histories contained within the State's

Child Welfare Services/Case Management System (statewide case management system). State regulations require county CWS agencies to consider certain factors when determining their responses to referrals, such as the nature of the alleged incident; the child's history of maltreatment; and the caregiver's history of substance abuse, mental health problems, and criminal behavior. We examined the accuracy of information included in the agencies' initial intake documents, which include a screener narrative that generally summarizes the allegation,<sup>3</sup> the parties involved, and, in some counties, the household's CWS history; an emergency response referral information form (referral form) that provides details on information that was obtained from and entered into the statewide case management system; and a SDM hotline tool (described in the Introduction).

In our review of 40 referrals at each of the three counties, we found that 10 Orange County intake files were inaccurate in some manner, as were seven intake files in both Butte County and San Francisco County. However, many of these inaccuracies did not result in a change to the priority placed on the referral. Typical errors included not identifying all potential victims (such as all siblings) and perpetrators (such as both parents), not consistently identifying the main abuse categories, and not incorporating all relevant information into the response timing decision. As indicated in Table 4, a total of eight of these 24 errors affected the decision of how quickly to respond to a referral.

**Table 4**  
**Factual Consistency of the Initial Intake Documents**

LEVEL OF CONSISTENCY	COUNTY CHILD WELFARE SERVICES (CWS) AGENCY			TOTAL
	BUTTE	ORANGE	SAN FRANCISCO	
Factually consistent	33	30	33	96
Not factually consistent: did not affect response decision	3	7	6	16
Not factually consistent: affected response decision	4	3	1	8
<b>Total referrals reviewed</b>	<b>40</b>	<b>40</b>	<b>40</b>	<b>120</b>

Source: California State Auditor's review of 40 referrals each at the CWS agencies for Butte, Orange, and San Francisco counties.

With regard to the higher number of inaccuracies we observed in the intake files of the Orange County CWS agency, we noted that this agency included more detailed information in its initial intake documents, which in our view were better prepared but

<sup>3</sup> Butte County does not typically use the screener narrative form. Instead, it includes an allegation summary with this information in the alerts section of the referral form.

ultimately provided more opportunity for small errors to occur. Although Orange County had a higher number of total inaccuracies than the other two CWS agencies, the number of instances in which the inaccuracies affected the response priority assigned to its referrals was lower than that for Butte County.

The hotline tool is an SDM form used to determine whether an in-person response to a referral is necessary and, if so, how quickly the agency must respond—either immediately or within 10 days. The hotline tool is made up of two sections. The first section identifies the type of abuse or neglect noted in the referral and determines whether an in-person response is necessary. The second section employs one or more decision trees based on the type of abuse or neglect reported to establish the appropriate response time.

Although our review of Butte, Orange, and San Francisco counties revealed that the hotline tool was generally used once a referral was received, we found eight instances in which inaccuracies among the initial intake documents caused the county CWS agency to establish a later response time than was appropriate. For example, in Butte County we found an instance in which a file's hotline tool indicated a necessary response time of 10 days for a referral alleging sexual abuse and general neglect. Because the screener narrative describing the allegation indicated that the alleged perpetrator had access to the child within the next 10 days, the referral would have required a 24-hour response priority if the social worker had used the hotline tool appropriately. Similarly, in San Francisco, a screener narrative included allegations of physical abuse, but the referral form and hotline tool indicated emotional abuse. Had the physical abuse allegation been included in the hotline tool, the physical abuse decision tree would have recommended a 24-hour response instead of the 10-day response assigned. When CWS agencies make inappropriate decisions regarding referral response times, children may be exposed to additional abuse or neglect.

***When CWS agencies make inappropriate decisions regarding referral response times, children may be exposed to additional abuse or neglect.***

In addition, errors recorded in the referral form, which contains the information entered into the statewide case management system, sometimes indicated that the intake social worker had entered incomplete or inaccurate information into the system. Such errors were typically related to either incomplete documentation of all involved individuals (that is, victims or perpetrators) or an incorrect category of alleged child maltreatment. Categories of maltreatment include severe and general neglect as well as physical, sexual, and emotional abuse. Overall, we found that referral forms for a total of 12 of the referrals we reviewed across the three counties contained errors that remained in the statewide case management system at the time of our review. Of these, six referrals (three each in Orange and San Francisco counties) did not accurately document the individuals involved. For example, one of the San Francisco

referrals we reviewed described a situation in which police arrested a man for illegal drug possession while his wife and children were in the car. However, the referral form does not list him as a perpetrator; instead, it identifies only his wife as a perpetrator of general neglect against the children. We also found six referrals (three in San Francisco County, two in Orange County, and one in Butte County) in which errors regarding the category of alleged maltreatment led to inaccurate and incomplete information in the statewide case management system. In Butte County, for example, a referral form was missing an allegation of physical abuse, despite the fact that, according to the allegation summary, the allegation involved a sibling's father, who was residing in the home and reportedly punching the child in the head. Such discrepancies can lead to certain referrals or allegations not being included in the victims' and perpetrators' history in the statewide case management system; thus, subsequent investigators receive inaccurate and incomplete information.

State regulations require supervisors to approve referral intake response decisions, but they do not require supervisors to review the hotline tool. Likewise, the SDM manual—which all three county CWS agencies follow—contains no requirement for supervisor oversight of the hotline tool. Orange County's CWS agency policies require supervisory oversight of the intake process, including both the response decision and the hotline tool—a policy we believe to be a best practice. Neither Butte County nor San Francisco County CWS agencies have equivalent policies. Supervisors in Orange and Butte counties provided oversight of the intake process in 39 and 34 of the 40 referrals we reviewed at each county, respectively. Supervisors in San Francisco County provided oversight in only 18 of 40 referrals.<sup>4</sup> San Francisco's deputy director of Family and Children Services (deputy director) stated that it is not currently clear exactly what proportion of response decisions receive supervisory oversight, but that it is likely more common than the instances we found in our review. We agree it is possible that insufficient documentation of oversight contributed to what we found. However, given the inconsistencies we identified in the referral intake documents during our review, we believe requiring documented supervisory oversight in Butte and San Francisco counties would greatly reduce inaccuracies and better ensure that social workers make appropriate decisions. The fact that inaccuracies persisted in Orange County despite that agency's aforementioned policy indicates that agency management should take steps to ensure that all supervisors understand the hotline tool and regularly review their staff's use of the tool.

***Supervisors in San Francisco County provided oversight of the intake process in only 18 of 40 referrals.***

<sup>4</sup> Unlike the two other county CWS agencies, the San Francisco County CWS agency frequently did not use a field in the statewide case management system that indicates supervisory approval of referral response decisions.

### **Although the Counties We Visited Generally Attempted Timely In-Person Investigations, They Were Not Always Successful in Establishing Contact With Alleged Victims**

The county CWS agencies we visited generally attempted to contact the victims of alleged maltreatment in accordance with state laws and guidelines, but the agencies were not always successful in making contact in a timely manner and did not always follow up on unsuccessful contacts within a reasonable time frame. State laws and regulations and county policies dictate the time frame within which social workers must make in-person responses to allegations. As discussed previously, a social worker screens each call to the child abuse hotline and uses a hotline tool to determine the appropriate response. Depending on the severity of the allegation, the social worker must respond in person either immediately, in cases of imminent danger to the child, or within 10 calendar days. To fulfill this requirement, state regulations require social workers to have in-person contact with all alleged child victims. State laws and regulations do not define *immediately*, but county policies generally require such responses to take place in 24 hours or less. If an initial attempt to visit a child is unsuccessful (for example, if the family is not at home), CWS workers would need to perform follow-up visits to ensure that the child is safe. Although state laws and regulations do not address requirements for follow-up attempts, Orange County policy directs workers to make additional attempts at contact as soon as possible, and no less than once every five business days, until contact is made. We applied this five-business-day standard to review the follow-up efforts of Orange County social workers as well as the efforts of social workers in Butte and San Francisco counties, whose policies are silent on this issue.

The CWS agencies we visited generally attempted to make in-person contact with the alleged victim of abuse or neglect within the required 24-hour or 10-day time frame. Our review confirmed that Orange County successfully completed or attempted to complete in-person contacts for all 40 referrals we reviewed by the assigned deadline. In Butte and San Francisco counties, this was true for 39 and 36 of 40 referrals, respectively.

***Although they generally made timely initial attempts at contact, the three counties were often not successful in making in-person contact with alleged victims within the required time frames.***

We noted that although they generally made timely initial attempts at contact, the three counties were often not successful in making in-person contact with alleged victims within the required time frames. For example, as Table 5 shows, Butte County made contact with the alleged victims by the response deadline in only 29 of the 40 referrals we reviewed. Of the remaining 11 referrals, Butte County made timely follow-up attempts for three of the initially unsuccessful attempts. However, the county social workers

failed to follow up on the remaining eight referrals soon after the unsuccessful initial attempt. As indicated in Table 5, the other two county CWS agencies had similar failure rates.

**Table 5**  
**In-Person Investigation Completion Rates by County**

RESULTS OF OUR REVIEW	COUNTY CHILD WELFARE SERVICES (CWS) AGENCY			TOTAL
	BUTTE	ORANGE	SAN FRANCISCO	
Completed on time*	29	27	28	84
Not completed on time: timely follow-up efforts <sup>†</sup>	3	6	7	16
Not completed on time: untimely follow-up efforts <sup>†</sup>	8	7	5	20
<b>Total referrals reviewed</b>	<b>40</b>	<b>40</b>	<b>40</b>	<b>120</b>

Source: California State Auditor’s review of 40 referrals each at the CWS agencies for Butte, Orange, and San Francisco counties.

\* These results do not include attempted visits where the social worker failed to make a successful in-person contact with the alleged victim.

<sup>†</sup> We measured timely follow-up using the Orange County CWS agency’s policy of follow-up needing to occur within five business days.

Despite being the only county CWS agency we visited with a policy governing efforts to contact alleged victims after an initially unsuccessful attempt, Orange County social workers did not attempt to make another contact with a child within five business days, as required in its policy, in seven referrals. We noted five instances among these seven in which the Orange County social worker did not make a follow-up attempt for at least two weeks. Similarly, when initial attempts were unsuccessful, social workers in San Francisco and Butte counties did not always follow up within five business days. For example, in one instance a Butte County social worker did not try to contact an alleged victim until more than three weeks after the worker’s initial unsuccessful attempt. By that time, the home at the family’s address on record was vacant. In San Francisco County, the longest such delay between attempts was 15 days.

Further, we noted a total of four instances, three in Butte County and one in San Francisco, in which the county CWS agencies—after successive failed attempts at making in-person contact—closed the referral. In one of the instances in Butte County, the agency received a report alleging that a woman was using drugs in her child’s presence and not providing adequate care. The social worker made one unsuccessful attempt at contact at the woman’s home. Soon after, another individual called in a similar report regarding the same woman and indicated where the woman would be staying for the next two weeks. Despite receiving this report, the social worker waited 20 days before making a subsequent unsuccessful attempt to locate the woman at her original address instead of at the reported updated location. A Butte County Department of Employment and Social Services

***In one instance, less than four months after the Butte County CWS agency closed the initial referral, the same child was the victim of substantiated neglect.***

program manager (program manager) stated that social workers must have a reasonable expectation of a child's specific location in order to attempt contact. Based on the case notes, it appears that the county did have a reasonable expectation based on this information. After several additional unsuccessful attempts to contact the mother by phone and mail, the social worker closed the referral. There was no indication that the social worker ever attempted to visit the other reported location or to contact the reporters, both of whom were relatives of the child, to gather further information regarding the mother's whereabouts. The program manager cited the agency's lack of a written policy that specifies the number and frequency of follow-up attempts and the method social workers should pursue when making these attempts as the reason for the social worker's inadequate investigation. Less than four months after the initial referral was closed, the same child was the victim of substantiated neglect.

In the one instance we identified in San Francisco County, a social worker attempted contact nine times between early July and mid-August before finally deciding to close the referral as a result of the failed attempts. However, our review noted that the worker handled the first eight of those attempts in exactly the same manner—by leaving his business card at the residence on record for the family. The worker did not attempt an alternate means of contact, such as visiting the children's schools, until more than eight weeks after the initial referral. A San Francisco County Family and Children Services manager (department manager) stated that the individual making the referral did not state which schools the children attended and that the worker followed current county protocol. However, the department manager did not clarify why it took the worker more than six weeks to identify the schools, and we found no written protocol describing how to conduct follow-up attempts or when to close referrals when attempts at contact are unsuccessful. Three months after it closed the first referral, the San Francisco CWS agency received another referral—substantiated neglect against the mother—and removed the children from her care.

As discussed previously, San Francisco and Butte County CWS agencies lack policies regarding the frequency of social workers' follow-up attempts at contacting alleged victims. This may contribute to lengthy delays in some cases in achieving contact with the alleged victims. Further, these two counties do not have formal policies dictating how workers make follow-up attempts or when a referral should be closed because of failed contact attempts.<sup>5</sup> When the safety of the child is in doubt, the lack of specific

<sup>5</sup> The Orange County CWS agency has a policy describing the diverse follow-up efforts their social workers must perform before closing a referral because the family cannot be located.

guidelines means counties cannot be confident that social workers are making reasonable efforts to reach the child and prevent future maltreatment. Both county CWS agencies agreed that providing clear guidance to social workers regarding what is expected for follow-up attempts—in terms of both frequency and method—would be good practice.

### **The Assessments County Social Workers Completed During Their Investigations Contained Inaccurate Information, Sometimes Leading to Questionable Decisions**

In addition to the inaccurate information we identified in the initial intake documents, as discussed previously, our review discovered that social workers did not always prepare the required standardized assessments during the course of their investigations and, when they did, the assessments frequently contained inaccurate information. As a result of these inaccuracies, subsequent decisions about the related cases—including conclusions about the allegations in question and determinations regarding whether to remove children—may have been predicated on faulty information and therefore may not have been appropriate. Further, supervisors did not always review these assessments in a timely manner, potentially contributing to the inaccuracies we found.

### ***Inaccurate Safety Assessments Undermined Workers' Conclusions About Children's Safety***

While investigating maltreatment allegations, social workers at the three county CWS agencies we visited did not always complete the required safety assessment in a manner substantially consistent with the case history and the facts of the allegations. Further, in Butte and San Francisco counties, social workers sometimes did not complete the assessment at all. This assessment is an element of the SDM tools described in the Introduction; it is designed to help the social worker determine whether it is safe for the child to remain in the home and, if so, whether additional intervention is required to ensure that safety. As indicated in Table 6 on the following page, the Butte and San Francisco County CWS agencies had the most difficulty in preparing accurate safety assessments. In our review of 40 referrals in Butte County, we determined that six assessments were not completed and three were not substantially consistent with information available to the social worker at the time the assessment was completed. San Francisco had even more problems with accuracy: eight safety assessments were not substantially consistent with available information; in addition, four were not completed. Typical inaccuracies included a social worker failing to note a caregiver's substance abuse or domestic violence issues.

***In Butte and San Francisco counties, social workers sometimes did not complete the required safety assessment at all.***

**Table 6**  
**Factual Consistency of the Safety Assessments**

ACCURACY OF SAFETY ASSESSMENTS	COUNTY CHILD WELFARE SERVICES (CWS) AGENCY			TOTAL
	BUTTE	ORANGE	SAN FRANCISCO	
Substantially consistent	31	38	28	97
Not substantially consistent	3	2	8	13
Not performed	6	0	4	10
<b>Total referrals reviewed</b>	<b>40</b>	<b>40</b>	<b>40</b>	<b>120</b>

Source: California State Auditor's review of 40 referrals each at the CWS agencies for Butte, Orange, and San Francisco counties.

Because this assessment is the main tool used to determine whether a child faces immediate safety threats, failure to complete or accurately complete the assessment means that social workers could reach an improper conclusion in deciding whether to remove the child. In one example in Butte County, a parent refused to allow a social worker access to her home and children during an investigation of alleged child neglect because of the parent's alleged substance abuse. The parent stated that the child who was the focus of the referral refused to speak with the social worker and expressed anger that the social worker had interviewed the child's younger sibling at school. The social worker apologized for performing this required action and agreed not to interview the child. All observations related to the home were made based on what could be seen from the home's porch. The safety assessment associated with this investigation indicated *no* for the safety threat of "The family refuses access to the child . . .", indicated *no* for substance abuse, and indicated *yes*, among eight other protective capacities, for "the caregiver was willing to accept temporary interventions offered by the worker . . . including cooperation with continuing investigation/assessment." Finally, the worker concluded on the safety assessment that no intervention was needed and that the child was safe. Three weeks later, the child was the subject of another allegation, this time for abuse as well as neglect. The child was willing to speak with the assigned social worker, and the allegation of neglect was substantiated.

For most of the inaccuracies we found, such as the example just discussed, the social worker completing the safety assessment left out key safety threats, which sometimes led to children remaining in unsafe situations. However, in two instances in San Francisco, the social worker based the decision to remove a child at least in part on safety threats that information in the case file did not support. In the first instance, the county court ultimately agreed with the social worker's decision to remove the child. In the second instance, the child was not removed because the mother fled with the child

and could not be located. We did not find any instances in Butte or Orange counties in which assessments contained safety threats that available information did not support.

The SDM manual states that the safety assessment “guides the decision about whether the child may remain in the home,” but the assessment does not include a clear decision-making mechanism. Therefore, we were not always able to conclude that inaccurate assessments led social workers to improper safety decisions. However, given the purpose of the assessment, any substantial inaccuracy or inconsistency in its completion could lead to a decision that jeopardizes a child’s safety or contributes to a child’s improper removal.

***County Social Workers at Times Relied Upon Inaccurate Information in Deciding Whether to Open CWS Cases***

In their completion of the second standardized investigation tool—the risk assessment—the counties were even less accurate than for the safety assessments. Risk assessments represent a social worker’s judgment of the likelihood of future maltreatment. When completed, they provide the social worker with direction as to whether to close a referral or to elevate the referral to an open CWS case. A child with an open CWS case receives regular follow-up visits from a social worker, who continues to monitor the care the child is receiving. Therefore, inaccurate risk assessments can lead to inappropriate decisions regarding whether a child should receive these ongoing services. As shown in Table 7 on the following page, our review of 40 referrals in San Francisco County found only 13 in which the risk assessment was substantially consistent with the information available at the time. For 15 referrals, the inaccuracies in the risk assessment did not change the decision the social worker ultimately made about the referral. In two instances, however, the inaccuracies led to a decision to open a case that a correctly prepared risk assessment would not have recommended.<sup>6</sup> Additionally, four required assessments were not performed at all. The table displays similar issues with the risk assessments in Butte and Orange counties.

***We did not find any instances in Butte or Orange counties in which assessments contained safety threats that available information did not support.***

<sup>6</sup> In one of these instances, the San Francisco County CWS agency closed the case within a month; in the other instance, the agency closed the case after 10 months of family maintenance services.

**Table 7**  
**Factual Consistency of the Risk Assessments**

ACCURACY OF RISK ASSESSMENTS AND EFFECT ON DECISION AS TO WHETHER TO OPEN A CASE	COUNTY CHILD WELFARE SERVICES (CWS) AGENCY			
	BUTTE	ORANGE	SAN FRANCISCO	TOTAL
Substantially consistent with case information	20	27	13	60
Inaccuracies exist, but had no effect on decision	6	10	15	31
<b>Inaccuracies exist and led to an incorrect decision</b>	0	3	2	5
Assessment required but not performed	9	0	4	13
Assessment not required*	5	0†	6	11
<b>Total referrals reviewed</b>	<b>40</b>	<b>40</b>	<b>40</b>	<b>120</b>

Source: California State Auditor’s review of 40 referrals each at the CWS agencies for Butte, Orange, and San Francisco counties.

\* The *Structured Decision Making System: Policy and Procedures Manual* requires social workers to complete risk assessments only for substantiated and inconclusive referrals. The manual recommends the completion of risk assessments for referrals determined to be unfounded.

† Orange County’s policy is to require risk assessments for all investigated referrals, including those that social workers determine to be unfounded.

Once completed by the social worker, the risk assessment provides the social worker with a separate numerical score for neglect risk and abuse risk. As Figure 3 illustrates, these scores in turn correspond to one of four risk levels. The SDM manual instructs the user to select the higher of the neglect and abuse risk levels. If the ultimate risk level is “high” or “very high,” the default decision is to open a case as a result of the referral. If the ultimate level is “low” or “moderate,” the default decision is to close the referral. As such, among the inaccurate assessments we identified, some inaccuracies resulted in no change in the risk level and others resulted in an incorrect risk level but not an incorrect decision.

**Figure 3**  
**Risk Assessment Scoring and Recommended Decision**



Source: Children’s Research Center, *The Structured Decision Making System: Policy and Procedures Manual*.

As discussed, in some instances the inaccuracies social workers made in completing risk assessments led them to an incorrect default decision. This occurred three times at the Orange County CWS agency and twice at the San Francisco County CWS agency. In one example at Orange County, the social worker failed to indicate the caregiver's prior substantiated neglect, mental health concerns, and alcohol abuse on the risk assessment, although all three issues were present in other case documents compiled before the assessment was prepared. A supervisor for Orange County's quality support team confirmed that the social worker failed to capture these issues. As a result, the assessment indicated a low risk score when the score should have been high, resulting in a default decision to close the referral rather than the correct default decision to open a CWS case.

In Butte County we found six inaccurate risk assessments, but none affected the ultimate decision as to whether to open a CWS case.<sup>7</sup> The more frequent problem in Butte County was social workers not performing required risk assessments. Although they did not formally complete nine required risk assessments (of the 40 referrals we reviewed), Butte County social workers still offered a risk-level determination in their investigative narratives for seven of these referrals. To assess these determinations, we completed a risk assessment tool based on the available information and compared the risk level derived from our completed assessment with the risk level the social worker determined without using the tool. In four instances, the social worker's risk-level determination did not match what a correctly prepared risk assessment would have determined; however, only two of these risk-level inaccuracies would have affected the decision to open a case.

In the first instance, an accurate risk assessment would not have recommended that the referral be opened as a case, but the social worker opened a CWS case (the social worker obtained an agreement from the parent to participate in services, returned the child to the home four days later, and closed the case within three months). In the second instance, the social worker concluded, without filling out the risk assessment, that the risk of future neglect was low and closed the referral, despite numerous factors indicating that the neglect risk was high. Less than two months later, the Butte County CWS agency received another referral for this family, alleging the same neglectful conditions. This time the agency determined the neglect risk to be very high but did not open the case because the family moved and the agency did not have a new address for them. According to a Butte County program manager,

***In Butte County social workers made risk level determinations without actually completing the required assessments. In four of seven instances, these determinations did not match what a correctly prepared assessment would have determined.***

<sup>7</sup> In one of these six instances, the inaccuracies in the assessment caused the risk level and default decision to be incorrect, but the social worker overrode the incorrect default decision, making the errors essentially moot.

there was no requirement to complete the initial risk assessment because the home was determined to be conditionally safe.<sup>8</sup> However, the SDM manual expressly requires a risk assessment be completed for all substantiated referrals, as was the case in this situation. Had a risk assessment been correctly completed, the social worker could have opened a case and provided services to the family before losing contact.

***Inadequate Oversight of Investigative Assessments Exacerbates Issues With the Assessments’ Accuracy***

Our review indicated that supervisors do not always review social workers’ risk and safety assessments in a timely manner, possibly contributing to the problems we found with those assessments. No state law or regulation dictates requirements for supervisory review of these assessment tools. All three of the county CWS agencies have policies requiring supervisory review; however, only Orange County has a policy specifying a time frame for this review: within 30 days of being submitted for approval.<sup>9</sup> At all three counties, however, we noted that it was not uncommon for such approval to take more than a month. As Table 8 indicates, supervisors at these counties approved between 62 percent and 78 percent of safety assessments within one month of their completion. For approval of risk assessments within one month, the rate was 73 percent at all three counties.

**Table 8**  
**Percentage of Supervisory Reviews of Investigative Assessments and Decisions Completed Within 30 Days**

COMPONENT OF INVESTIGATION	COUNTY CHILD WELFARE SERVICES (CWS) AGENCY		
	BUTTE	ORANGE	SAN FRANCISCO
Safety assessment	62%	78%	75%
Risk assessment	73	73	73

Source: California State Auditor’s review of 40 referrals each at the CWS agencies for Butte, Orange, and San Francisco counties.

<sup>8</sup> The term *conditionally safe* refers to a safety assessment determination that a child can remain at home under a safety plan to mitigate safety risks.

<sup>9</sup> Because a number of safety and risk assessments were formally submitted to supervisors long after the social workers completed them, we used 30 days from assessment completion as our standard for evaluating timely supervisory review. Although this does not align perfectly with Orange County’s policy, using this benchmark appeared to be a more reasonable assessment of the timeliness of supervisory review, given that supervisors should be making sure that assessments are submitted on time.

The lack of timely supervisory review of risk assessments is problematic in light of the three CWS agencies' accuracy problems described earlier. An example from San Francisco County illustrates the importance of supervisory review in preventing inappropriate action. In this instance, errors on the risk assessment resulted in a decision to close the referral; however, our review determined that the risk level for this referral warranted opening a case. If a supervisor had not overruled the suggested action and opened the case anyway, ultimately resulting in the removal of an endangered infant, the referral would likely have been closed. When social workers' assessments do not receive this level of timely supervisory oversight, county CWS agencies may allow preventable errors that put children's well-being at risk.

### **Documentation of Investigative Results Varied in Quality Among the Three Counties**

We found substantial variation in the quality of the investigative narratives county social workers prepared to document the results of their investigations. Although there are no standardized requirements for investigative narratives, each of the three counties requires its social workers to complete them. However, the templates social workers use to complete these narratives differ substantially at each of the three counties. Orange County social workers use a template that includes standard sections for discussing key investigative elements, such as the family's history of CWS involvement, all investigative contacts, pertinent medical information, and any applicable court or police involvement in the referral. Consequently, the narratives we reviewed from the Orange County CWS agency were generally much more comprehensive and detailed than those from either the Butte or San Francisco County CWS agencies. We found eight instances in San Francisco County in which the social worker did not prepare an investigative narrative at all.

According to the deputy director, San Francisco began requiring investigative narratives for all referrals only about two years ago, but the deputy director could not provide the exact date that this change occurred. Because of that, we could not determine whether all of the missing narratives constituted violations of county policy. In five other instances in San Francisco County, the investigative narrative contained no substantive information or merely reprinted information verbatim from the initial intake documents. In these instances, we reviewed the case files for any additional documents containing narratives, but we also found inconsistent levels of detail there. For Butte County, the investigative narratives tend to be quite brief. According to its CWS assistant director, the investigative narrative is not intended to detail the social worker's investigation.

*We found substantial variation in the quality of the investigative narratives county social workers prepared to document the results of their investigations.*

***Although we found inaccuracies in the safety and risk assessments for all three counties, Orange County was generally more accurate in its completion of both assessments.***

Rather, its purpose is to provide summary information. However, in three instances, the investigative narratives did not adequately provide even a summary of the information the social worker gathered during the investigation.

Because the standardized risk assessments discussed earlier draw on investigative findings, it is possible that the variation in the three counties' investigative narratives contributed to the problem of inaccurate assessments. Indeed, although we found inaccuracies in the safety and risk assessments for all three counties, Orange County was generally more accurate in its completion of both assessments. Further, incomplete or imprecise investigative narratives are of little use to subsequent county workers who may be examining the circumstances of a past investigation while investigating a new referral or handling the resulting ongoing case. San Francisco's deputy director agreed that expanding the narrative's template to include some key indicators found in the SDM assessments might help ensure that social workers are contemplating these issues as they investigate referrals. The deputy director also concurred that more complete narratives would help future social workers access information about a previous referral, even if that referral did not result in a formal case.

### **County CWS Agencies' Inadequate Safety Plans and Questionable Placement Decisions May Have Put Children at Risk**

Our review of the three county CWS agencies' decisions regarding the removal of children identified instances in which insufficient county intervention may have placed children at risk. When social workers determined that safety plans were necessary to allow children to remain in their homes, the workers often failed to complete such a plan or produced plans unlikely to mitigate the identified safety risks. Additionally, agencies allowed children to be informally placed or to remain in risky living situations outside of their homes rather than formally removing them from the custody of their parents. Finally, when the agencies formally removed children and placed them with relatives or family friends, social workers did not always perform background checks before making those placements.

### ***Inadequate Safety Plans Increased the Risk of Recurring Child Maltreatment***

At the three agencies we visited, we found that required safety plans were not being developed, that social workers were creating some plans that did not address all identified safety threats, and that social workers were instituting plans that were unlikely to

be effective given the family's history. As discussed earlier, social workers at all three of the county CWS agencies are required to use standardized safety assessments to determine initially whether a child must be removed from the home to ensure his or her safety. When a social worker determines that one or more safety threats to a child exist but immediate removal is not necessary, the SDM policies the three counties follow require the social worker to develop a safety plan designed to mitigate the identified safety threats so that the child can remain in the home. The safety plan describes specific and sufficient interventions that the parents agree to implement.

The frequency with which social workers concluded that a safety plan could mitigate safety risks varied among the three counties as did the extent to which the plans those workers developed could reasonably be expected to mitigate the risks in question. Orange County social workers most frequently determined that safety plans would mitigate the need for removal. However, of 22 referrals for which Orange County social workers determined such plans were needed, the social worker did not complete a plan for three of them. Our review found mention of one of these missing plans elsewhere in the files, but as the SDM manual requires a form on which caregivers agree to and sign all pertinent safety plans, a mere description is not enough to document a plan's existence. Further, we determined that five of the 19 safety plans that were included in the county's files were inadequate to mitigate the safety threats to the child, based on information in the current allegations and case history.<sup>10</sup> These safety plans were inadequate because they were dependent on the following:

- The credibility and suitability of a nonrelative caregiver for whom the social worker did not conduct any history checks (and who ultimately proved to be a felon who had lost custody of her own children).
- The protective capacity of a mother who had expressed doubt about her daughter's sexual abuse allegations against the stepfather and who had previously failed to intervene when the daughter described the stepfather's behavior.
- The ability of a known drug user simply not to use drugs.

***When a social worker determines that one or more safety threats to a child exist but immediate removal is not necessary, the social worker must develop a safety plan designed to mitigate those safety threats.***

<sup>10</sup> We noted three other instances in Orange County where social workers failed to follow agency policy on information to be included in its safety plans (each child involved, person to monitor intervention, and time frame for intervention); however, we concluded that these three plans were otherwise adequate.

- A safety plan that did not obtain agreement from the parents to take steps to end the domestic violence that sparked the original referral but rather to call law enforcement should domestic violence occur again.
- A safety plan that required the parents to not neglect their child's needs. Within the context of the referral, this vague requirement likely meant that the parents needed to fill the child's prescriptions, ensure the child took vital medications, and take the child to medical appointments. However, the safety plan did not specify this and, as documented in a subsequent substantiated referral, the parents did not complete these activities.

In these five instances, social workers predicated their decisions to leave children in the home on the existence of safety plans that could not reasonably have been expected to succeed, thereby putting those children at further safety risk.

Social workers in San Francisco and Butte counties were less likely than those in Orange County to employ safety plans. However, we determined that San Francisco County social workers completed a safety plan for only four of 10 referrals for which the worker had indicated that a plan was required to keep the child safe. Further, one of the four plans was unlikely to mitigate the safety threats in question. In that instance, a social worker instituted a safety plan to mitigate a domestic violence threat that required the mother to keep her abusive boyfriend out of the home. However, the worker was aware that a restraining order was already in effect against the boyfriend and that neither the mother nor the boyfriend had been observing that order. Days later, the boyfriend once again returned home and became violent, resulting in the removal of the child. Of the 13 referrals we reviewed for Butte County that indicated the need for safety plans, we found only four had completed plans, all of which appeared to be adequate.

***The frequency with which social workers failed to complete safety plans that they themselves determined were necessary to protect children points to a major disconnect in agencies' effective use of the standardized SDM system, especially as it relates to early decisions about the child's safety.***

The frequency with which social workers failed to complete safety plans that they themselves determined were necessary to protect children points to a major disconnect in agencies' effective use of the standardized SDM system, especially as it relates to early decisions about the child's safety. Further, the fact that the plans social workers did create were often inadequate to address the safety threats they identified, suggests a limitation in the methods agencies employ to create these plans. The lack of evidence of supervisory review of many of these plans underscores this concern. Three of the four plans we reviewed in Butte County lacked evidence of such oversight, as did three of four plans in San Francisco County. The rate of reviews in Orange County was slightly better, with seven of 18 safety plans showing evidence of

supervisory review. According to the director of the Butte County Department of Employment and Social Services, the agency needs to improve its documentation of supervisory review of safety plans, stating that supervisors review all safety plans before a referral is closed. However, social workers may take up to 30 days or longer to close a referral. Consequently, we believe it would be more appropriate for the supervisor to review the safety plans soon after they are implemented, to better ensure the plan's ability to mitigate the safety threats in the home.

### ***CWS Agencies Sometimes Allowed Potentially Risky Living Arrangements Rather Than Formally Removing Children***

Our review identified instances in each of the three counties in which a social worker left a child with family or others as temporary living arrangements, but the social worker did not take additional steps to ensure that these caregivers were appropriate. One way this type of arrangement arises is when the social worker allows a child to stay with an alternate caregiver with the consent of a parent or guardian while the social worker concludes the investigation into the allegations. Because these children are not being detained by the CWS agencies, social workers are not required to perform critical criminal background or CWS history checks on the temporary caregivers. Of the 40 referrals we reviewed in San Francisco, we identified eight instances of these arrangements in which the social worker did not perform any checks on the temporary caregiver. We also identified one such instance in Orange County and one in Butte County.

The inherent risks associated with these arrangements could have been prevented with basic inquiries into the caregivers' histories. For example, during an investigation into neglect of a medically vulnerable infant, a neighbor of the alleged perpetrator declared herself to an Orange County social worker as "the principal caregiver" for the infant because the mother was a transient. The social worker met with the neighbor and encouraged her to obtain the mother's authorization to access medical care for the child—because of the child's special needs—but made no further inquiries into this person's background at the time. Two weeks later, after hospital staff reported to the social worker that the infant was not being brought in for its vital medical appointments, the social worker made a formal inquiry into the caregiver's background and discovered not only a 10-year history of violent crime and drug-related arrests but also a significant history of CWS intervention—including losing custody of her own children. A supervisor for Orange County CWS agency's quality support team

***When social workers allow children to stay with alternate caregivers while they conclude investigations into the allegations, the social workers are not required to perform critical criminal background or CWS history checks on the temporary caregivers.***

confirmed that the agency did not perform any check until 10 days after learning this individual was caring for the child and stated that ideally a history check would have been run more promptly.

In an example from San Francisco County, the social worker allowed a child to remain in a grandparent's home for a week leading up to a court hearing while the alleged perpetrator was in and out of that home. The social worker appears to have done so without making any inquiries into the grandparent's history, despite observing during the investigation that the grandparent appeared to be under the influence of drugs. At the court hearing, the agency subsequently recommended that the grandparent not be considered for official placement, in part because of the grandparent's extensive CWS history. However, the social worker also had access to this CWS history and could have checked it before leaving the child with the grandparent. A San Francisco County department manager stated that it is unknown why the child remained in the home of the grandparent for the period leading up to the hearing with no history checks. In this case, the unsuitability of the temporary living arrangement with the grandparent would likely have come to light from even a cursory initial inquiry by the social worker.

***Failure to properly vet these types of arrangements, temporary though they may be, creates situations in which children remain at risk because they are in the care of someone with unknown history and in homes of unverified safety.***

Failure to properly vet these types of arrangements, temporary though they may be, creates situations in which children remain at risk because they are in the care of someone with unknown history and in homes of unverified safety. Orange County's CWS agency asserted that in these situations, they do not have the right to perform criminal background checks and our legal counsel agrees. However, our legal counsel believes that agencies are not restricted from looking up prospective caregivers within the CWS database as well as reviewing public criminal sites for this purpose, or simply asking a prospective temporary caregiver about his or her past. These two examples indicate that cursory research such as this would have revealed risks to the children in question sooner and could have prevented inappropriate living situations.

### ***County CWS Agencies Did Not Always Perform Even Basic Background Checks When Formally Placing Children With Caregivers***

When county CSW agencies formally remove children from the home, state law requires that the agencies ensure a safe placement for the child. To that end, when they place children in locations other than licensed facilities, such as the homes of relatives or nonrelative extended family members, state law requires the agencies to complete criminal background and CWS history checks on the proposed caregivers before placing the child in that setting.

Nevertheless, at the three agencies we reviewed, we found instances in which they did not perform the required background checks before placing the child in a relative's home.<sup>11</sup>

In Orange County, of 18 such placements, we identified two instances in which the background checks were completed after the child was placed in the home. This was true for one of four such placements in Butte County and for four of 18 placements in San Francisco. In one example from San Francisco, the social worker officially placed the child with a friend of the offending parent before obtaining the background check results for this new caregiver. As a result, the social worker did not discover until weeks later that the friend was a convicted felon who had met the parent at a substance abuse facility where they were both patients and that the friend had failed to complete the treatment program. After learning this, the agency ended the placement and returned the child to the parent, who had again started substance abuse treatment. A San Francisco department manager stated that the agency considered the mother a more appropriate placement at that point and noted that she was receiving treatment under the court's supervision. Although no harm came to the child in this instance and reunification happened relatively quickly, better placement practices may have prevented what was an inappropriate setting and the additional sudden removal for the child. Failure to complete these checks in a timely manner risks subjecting children who have already suffered maltreatment to further danger.

*At the three agencies we reviewed, we found instances in which they did not perform the required background checks before placing the child in a relative's home.*

### **Substantiation Rates of Allegations Varied Significantly Across the Counties We Visited**

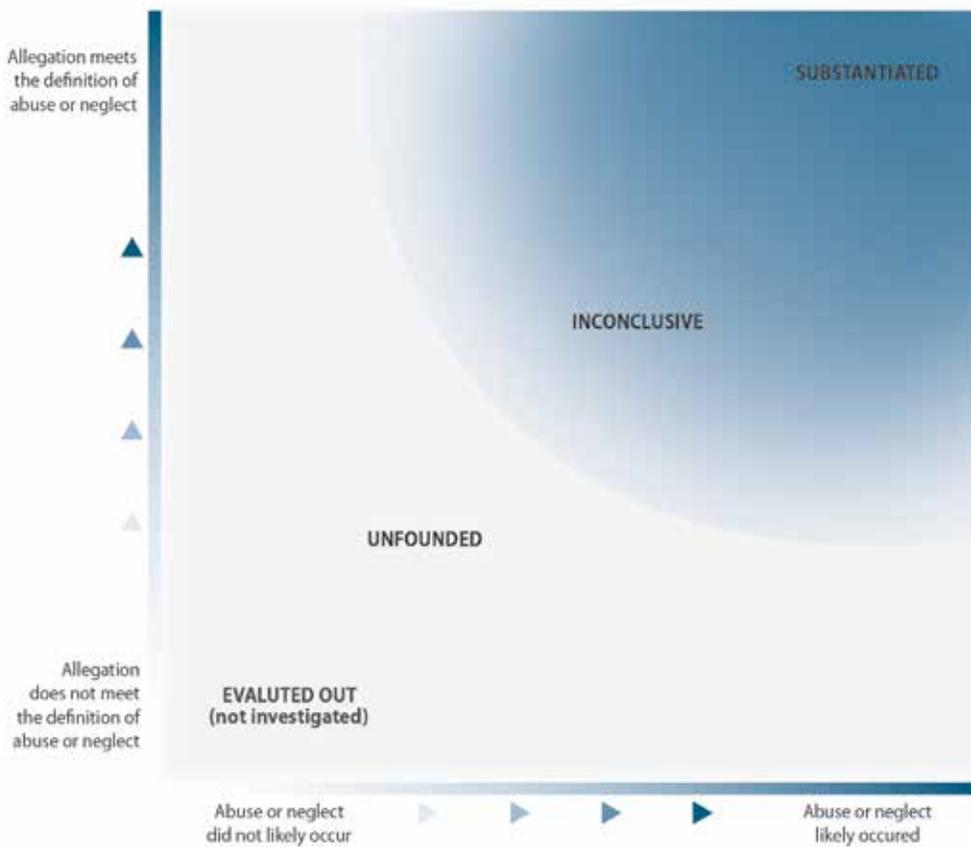
The county CWS agencies we visited varied significantly in the frequency with which they substantiated that child maltreatment had occurred. Although related to the previously discussed safety and risk assessments, whether to substantiate an allegation of abuse and neglect is a separate decision that can have lasting impacts, such as a person's inclusion on the Department of Justice Child Abuse Index. For child abuse or neglect to be substantiated, state law requires that a county CWS agency find "evidence that makes it more likely than not that child abuse or neglect, as defined, occurred."

As Figure 4 on the following page demonstrates, social workers must exercise judgment in two important ways when determining whether an allegation is substantiated, inconclusive, unfounded,

<sup>11</sup> In instances where the background checks and the child's placement occurred on the same day, we gave the counties credit for timely completion.

or not investigated at all. Beginning with the initial intake of an allegation, social workers determine whether the alleged abuse, if true, would constitute abuse or neglect. If not, the referral will typically be evaluated out, which means it will not be further investigated. The second determination, which is typically made after an in-person investigation, is whether the abuse or neglect likely occurred. In many instances, the answer to one or both of these questions might not be clear-cut and the ultimate determination is inconclusive. Unlike the safety and risk assessments, this decision does not appear to be made using a structured model or other instructions.

**Figure 4**  
Potential Outcomes for Child Welfare Services Allegations



Source: California State Auditor’s analysis of applicable state laws and regulations.

The statewide average for allegation substantiation in 2012 was 17.4 percent. Among all of the allegations San Francisco County received, only 11.5 percent were substantiated, compared to a substantiation rate of 23.7 percent in Orange County.

The substantiation rate in Butte County, at 16.3 percent, was closer to the statewide average. Although we cannot conclude that any one of these percentages is the “correct” proportion of allegations to substantiate, the previously discussed lack of policies at Butte and San Francisco counties concerning social workers’ follow-up attempts at contact may be contributing to these two counties’ lower substantiation rates. We found a total of four instances between Butte and San Francisco counties in which social workers closed the referrals without ever making contact with the alleged victims. In these instances, the social workers determined the allegations to be either unfounded or inconclusive, due not to the results of investigative work but rather as a result of not making contact with the victims.

Variation in the accuracy of investigative narratives and risk assessments raise further concerns that San Francisco may not be substantiating all allegations that warrant such action. In fact, in five of 40 referral cases in San Francisco, we found that the information in the county’s case file at the time of the determination did not support the social worker’s conclusion that the allegations were unfounded. For example, one case file suggests that the agency concluded that an allegation was unfounded because the mother agreed to subsequent drug testing. The willingness of the mother to engage in services should not be the determining factor in deciding whether past maltreatment meets the definition of abuse or neglect and is likely to have occurred. After the county issued the finding of “unfounded,” the mother ceased her participation in drug testing. Because the county had not substantiated the referral, it was unable to take additional steps to persuade the mother to participate and instead closed the referral. A department manager confirmed that no state or county policy indicates that such a consideration is appropriate in making an allegation determination.

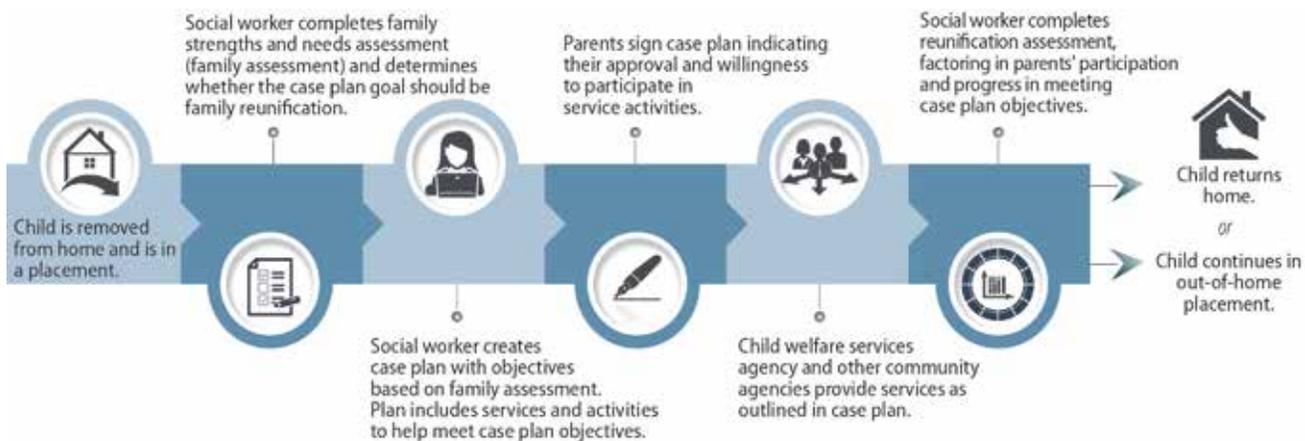
### **County CWS Agencies Did Not Always Appropriately Complete the Required Assessments Before Reunification**

The county CWS agencies we reviewed did not consistently and accurately complete family strengths and needs assessments (family assessments) and reunification assessments. Consequently, corresponding case plans outlining needed services, as well as decisions to reunify children with their parents, were less informed. After a child is removed from the home, the county CWS agency is responsible to work with the family to determine if reunification is an appropriate goal and to make corresponding recommendations to the dependency court. To assist in making these determinations, the policies of the three county

*Variation in the accuracy of investigative narratives and risk assessments raise further concerns that San Francisco may not be substantiating all allegations that warrant such action.*

CWS agencies require social workers to use SDM's family and reunification assessments. Figure 5 outlines how these assessments are used in deciding whether to return a child to the home.

**Figure 5**  
**Steps to Reunification**



Sources: California Department of Social Services Child Welfare Services Manual of Policies and Procedures and Children's Research Center, *The Structured Decision Making System: Policy and Procedures Manual*.

The purpose of the family assessment is to evaluate the strengths and identify critical family needs for every family involved in a referral that is opened as a case. Possible strengths include strong parenting skills or a strong social support system, while needs can range from moderate mental health issues to severe domestic violence or destructive parenting. This assessment helps ensure that families receive appropriate services and allows social workers to assess any changes in family functioning. For cases that required a family assessment, Orange County completed 97 percent of the assessments, San Francisco completed 97 percent, and Butte County completed 53 percent. According to the director of Butte County's Department of Employment and Social Services, the agency's social workers have struggled with the consistent use of the SDM assessment tools such as the family assessment. She further stated that the county is aware of this issue and has previously and will continue to provide training to address this concern.

When we compared the needs described in the family assessments with the files' case history, we found that they were not always consistent with issues identified during the investigation process. Of the 10 family assessments we reviewed in Butte County, one contained inconsistencies. Of the 29 and 34 family assessments we reviewed in Orange and

San Francisco counties, four and eight, respectively, were not consistent with issues identified during the investigation process. For example, a San Francisco family assessment failed to identify frequent domestic violence as a need to be resolved in the home, although such issues were mentioned in the detention report. Similarly, a Butte County family assessment made no mention of substance abuse, although the parent's use of drugs was the impetus for the referral. If critical family needs are missing from the family assessment, social workers risk omitting necessary services when creating the family's case plan.

After completing the family assessment, social workers collaborate with the parents or guardians to create a case plan. Based on the needs identified in the family assessment, the case plan identifies a case plan goal, which considers maintaining the child in the home with services, reunifying the child with the family, or placing the child permanently in out-of-home care. It also includes objectives, planned family services, and case management activities. We compared the needs identified in the family assessments with the case plans to determine whether the case plans, if followed, could effectively address the family's weaknesses. We found that agencies were generally consistent in addressing the needs identified in the family assessment in the subsequent case plan. However, when a family assessment is not prepared before the case plan is created or is not consistent with the case history, the subsequent case plan may not identify needed services. As a result, the social worker risks returning a child to a home where a threat of abuse or neglect still exists.

To help determine whether a child and his or her parents are ready for reunification, social workers are required to complete a reunification assessment tool. This tool allows social workers to reassess periodically the family's progress in achieving its case plan goal and to determine whether to return a child to the home, maintain out-of-home placement, or terminate reunification services and implement a permanent alternative such as adoption. The SDM manual requires social workers to complete the assessment only for cases in which the child has a reunification goal. For those cases, the assessment must be completed if six months have passed since the county began providing services to reunify the family and every six months thereafter.

We found that Orange and San Francisco counties almost always completed the required reunification assessments, while Butte County did not. Of the 40 cases we reviewed at each of the counties, Orange County was required to complete 22 reunification reassessments, under the guidelines described in the SDM manual, and both Butte and San Francisco counties were required to complete 12. Orange County completed 95 percent of the required reassessments. The completion rates for San Francisco

***We found that Orange and San Francisco counties almost always completed the required reunification assessments, while Butte County did not.***

and Butte counties were 92 percent and 83 percent, respectively. According to the director of Butte County's Department of Employment and Social Services, the county is working to improve its usage of SDM tools such as the reunification reassessment through employee and supervisor trainings.

The counties varied more notably in the timeliness with which they completed the required assessments, with Orange County completing 81 percent of its reassessments by the six-month deadline and at least once every six months thereafter. Butte County completed 70 percent of the required reassessments within the required time frame, and San Francisco did so at a rate of 64 percent. San Francisco's deputy director stated that there has been inconsistency in how the agency's social workers prioritize the timely completion of these reassessments and that improving performance in this area is a priority to the agency. Failing to complete the reunification reassessment could lead social workers to assess improperly the potential danger of a child returning to the home, while late reassessments mean a child could spend longer in an out-of-home placement than necessary.

### **Recommendations**

To ensure that referral response decisions are accurate:

- Butte and San Francisco County CWS agencies should develop policies requiring a supervisory review of the hotline tool and a monitoring system to ensure that supervisory reviews are completed.
- The Orange County CWS agency should ensure that all intake supervisors are trained on the use of the hotline tool and that they are regularly reviewing their staff's use of this tool.

To ensure that the statewide case management system contains accurate and complete information for each referral, Butte, Orange, and San Francisco County CWS agencies should update their policies or otherwise provide clear guidance to social workers about the importance of ensuring that all alleged perpetrators, victims, and types of maltreatment are accurately recorded upon intake.

To ensure that social workers are making reasonable and timely efforts to make in-person contact with children who are allegedly being maltreated, the CWS agencies in Butte and San Francisco counties should do the following:

- Develop clear policies for how frequently social workers must follow up with alleged victims in the event that initial attempts at contact are unsuccessful.

- Develop clear policies about the method and duration of social workers' attempts at making contact with hard-to-reach families, and clearly state under what circumstances a referral may be closed for lack of contact.

To ensure that its social workers are following its policy regarding timely follow-up visits, the Orange County CWS agency should provide training or other clarification of its policy and have its supervisors regularly review whether their staff are complying with this requirement.

To ensure that all required SDM assessments are completed, the CWS agencies of Butte and San Francisco counties should develop and implement clear guidance regarding which assessments are required in different situations.

To improve the timeliness and accuracy of SDM assessments, the CWS agencies of Butte, Orange, and San Francisco counties should ensure that their supervisors are promptly reviewing assessments.

To improve the timeliness of their supervisors' reviews:

- The CWS agencies of Butte and San Francisco counties should develop time frames for supervisors' review and approval of assessments and monitor supervisors' compliance with those time frames.
- The CWS agency of Orange County should more closely monitor supervisors' compliance with its existing policy setting a 30-day time frame for review and approval of assessments.

To improve the quality of the investigative information available to social workers, the CWS agencies of Butte and San Francisco counties should expand on their investigative narrative templates to include fields such as relevant criminal history, substance abuse, or mental health concerns.

To ensure that required safety plans are created, the CWS agencies of Butte, Orange, and San Francisco counties should have supervisors review all safety assessments in a timely manner and verify that a written safety plan signed by the responsible parties accompanies any assessments designating the need for a safety plan.

To help strengthen safety plans to effectively mitigate safety threats, the CWS agencies of Butte, Orange, and San Francisco counties should ensure that supervisors are reviewing and approving all safety plans.

As part of their responsibility to help children remain safe at all points during the investigation of a referral, the CWS agencies of Butte, Orange, and San Francisco counties should do the following:

- Vet temporary living situations and caregivers to the extent allowable under the law, including a review of information contained within the statewide CWS database.
- Perform statutorily required background checks and inspections *before* allowing children to be placed in a home.

## Chapter 2

### **THE COUNTY CHILD WELFARE SERVICES AGENCIES WE VISITED COULD IMPROVE THEIR COORDINATION WITH LOCAL LAW ENFORCEMENT AND THEIR IMPLEMENTATION OF QUALITY CONTROL PROCESSES**

#### **Chapter Summary**

Under the broad discretion state law and regulations afford, the child welfare services (CWS) agencies in the three counties we visited have adopted divergent approaches to coordinating with law enforcement in their investigations of reports of child maltreatment (referrals). Two of these agencies have cooperative agreements with local law enforcement and tend to collaborate with local law enforcement in their investigations and in removal of children from unsafe homes. Because of local preferences, the CWS agency in San Francisco does not have a similar agreement and tends not to involve local law enforcement in its efforts. This permissible preference notwithstanding, we found some instances in which communication between the CWS agency and local law enforcement in San Francisco could be improved.

We also found that all three of these agencies aspire to safety models considered best practices, but each agency could improve—to varying degrees—their use of fundamental management processes. In particular, management of the CWS agencies in Butte and San Francisco counties needs to communicate expectations better by developing clear, up-to-date policies and procedures. In addition, while the San Francisco CWS agency needs to develop a process for monitoring and improving the quality of its social work, both the Butte and Orange County CWS agencies could improve the practices or resources of their existing quality assurance units.

#### **County CWS Agencies Have Discretion in Coordinating Their Efforts With Law Enforcement, and County Policies and Practices Vary Accordingly**

State laws and regulations provide county CWS agencies with broad discretion in determining when to involve law enforcement in investigations and in removing children from their homes. Their policies and practices regarding involvement of law enforcement in CWS efforts reflect this flexibility. Even so, we found instances where coordination and communication between local law enforcement and the county CWS agencies we visited could have been better.

### ***State Laws and Regulations Give County CWS Agencies Broad Discretion in Determining When to Request Law Enforcement Assistance***

State laws and regulations provide county CWS agencies with broad discretion in determining when to involve law enforcement in child maltreatment investigations (investigations) and in removing children from their homes (removals). State regulations require CWS agencies to request law enforcement assistance when (1) the physical safety of family members or agency staff is endangered or (2) when a child must be placed in temporary custody and the social worker is not legally authorized to do so. Beyond these requirements, state laws and regulations provide no further guidance regarding when social workers should or should not request law enforcement assistance.

#### **Legal Authority to Remove a Child From the Home Without a Court Order**

If a child has an *immediate* need for medical care, or if the child is in *immediate* danger of physical or sexual abuse:

**Social workers** may place a child into temporary custody (remove him or her from the home) when:

- The child has suffered, or is at risk of suffering, physical harm due to a caretaker's failure or inability to adequately supervise or protect the child.
- The child has been left without any provision for support (for example, no caretaker is present).

**Law enforcement officers** may place a child into temporary custody under the abovementioned circumstances as well as in situations involving:

- Physical, emotional, or sexual abuse.
- The death of another child caused by the caretaker's abuse or neglect.
- The child being freed for adoption by the caretaker.
- The child being subjected to acts of cruelty due to a caretaker's failure to protect.
- The child being at risk where a sibling has been abused or neglected.

Source: California Welfare and Institutions Code, sections 300, 305, and 306.

Although some agencies have specified situations in which they want their social workers to call in law enforcement (such as when the presence of illegal drugs is identified), determining when physical safety is endangered is generally a subjective decision that is dependent on a social worker's judgment and the information available to him or her. Similarly, because many situations in which a child has suffered physical harm can be traced to a caretaker's failure to supervise or protect a child, and because the removal authority of social workers includes the particular phrase "or is at risk of suffering physical harm," most allegations that may result in removal could fall under both law enforcement's and social workers' statutory authority.<sup>12</sup> Consequently, deciding whether to bring law enforcement to an investigative visit that may result in a removal is a subjective judgment that, at least at the time of receiving the referral, is based on limited information.

We are not aware of any requirement that a CWS agency document why it did or did not involve law enforcement in its investigations or removals. The case management system that all county CWS agencies use has a field that specifies who removed the child—CWS or law enforcement; however, we found this field to be frequently inaccurate. Although we noted these administrative errors, we are not aware of any impact that they have.

<sup>12</sup> As noted in the text box, both social workers and law enforcement must have reasonable cause to believe that a child's *immediate* health or well-being is in danger before removing the child from the home without a court order.

Further, the level of discretion provided to county CWS agencies in including law enforcement in their efforts appears to be the type of flexibility envisioned by the county-administered model used in California.

***Variations in Levels of Law Enforcement Involvement in CWS Investigations Reflect Allowable Differences in County Policies and Philosophies***

The extent of law enforcement involvement in CWS investigations varies by county and generally reflects differences in county policies and philosophies related to requesting law enforcement assistance. We evaluated the extent of law enforcement involvement in a total of 120 county CWS agency investigations (40 at each of the three counties we visited). For each case, we determined whether the CWS agency had requested law enforcement assistance and whether this request appeared to be required by state regulations or was at least warranted given the circumstances of a referral. We determined that CWS requesting law enforcement assistance was warranted when the referral included potentially criminal allegations (such as sexual or physical abuse) or when doing so aligned with county policies, which we discuss later. In instances when law enforcement did not assist CWS, we examined whether information known to the social worker at the time would have required CWS to request law enforcement assistance under state regulations. Although we did not find any such instances in our review, we did find, as we describe later, an instance in which we believe a county CWS agency should have involved law enforcement in attempting to find an at-risk child.

Of the 40 referrals we reviewed in each county, law enforcement was involved in 19, 15, and six of the Butte, Orange, and San Francisco County CWS agencies' investigations, respectively. The high level of law enforcement involvement in Butte County CWS investigations includes two potentially related factors: the CWS agency in Butte County frequently requests law enforcement assistance and, more so than in the other counties we visited, law enforcement in Butte County often requests CWS assistance. Nearly half of the CWS investigations in which law enforcement was involved in Butte County stemmed from law enforcement requesting in-person CWS assistance. In contrast, only one CWS investigation each in San Francisco and Orange counties involved law enforcement making a similar request.

As indicated in Table 9 on the following page, the CWS agencies in Butte and Orange counties regularly involve law enforcement in their investigations, while the San Francisco CWS agency appears to rarely request law enforcement assistance. In addition, all of the

*The level of discretion provided to county CWS agencies in including law enforcement in their efforts appears to be the type of flexibility envisioned by the county-administered model used in California.*

referrals in which county CWS agencies involved law enforcement either were clearly required by state regulations or were warranted by the conditions described in the county CWS case files.

**Table 9**  
**Summary of Law Enforcement Assistance in Child Welfare Services Investigations**

LEVEL OF AND REASON FOR INVOLVEMENT	COUNTY CHILD WELFARE SERVICES (CWS) AGENCY			TOTAL
	BUTTE	ORANGE	SAN FRANCISCO	
No law enforcement involved in the CWS investigation	21	25	34	80
<b>Total with law enforcement involvement in CWS investigation</b>	19	15	6	40
Law enforcement requested CWS immediate assistance	9	1	1	11
Law enforcement involvement required by state regulations	1	3	1	5
Law enforcement involvement may not have been required by state regulations but appeared to be warranted*	9	11	4	24

Source: California State Auditor's review of 40 referrals each at the CWS agencies for Butte, Orange, and San Francisco counties.

\* We deemed law enforcement involvement warranted when their involvement was in accordance with established county policy or when referrals involved allegations of potentially criminal acts of abuse.

The differences we observed reflect variations in county policies and in expressed philosophies related to requesting law enforcement assistance. For example, a county protocol requires both CWS and law enforcement in Butte County to investigate whenever child maltreatment may be related to the use or manufacture of illegal drugs. Although these investigations can be performed separately, we observed a number of joint visits when drugs were involved. Also, while it is not required to do so, the Butte County CWS agency generally requests law enforcement assistance if a child is likely to be removed and encourages social workers to consider requesting law enforcement assistance when serving a court order to bring a child into protective custody. Similarly, the policies of the Orange County CWS agency require social workers to request law enforcement assistance in investigations that may result in a child removal or a police report, and when serving a warrant to gain entry to a home. In contrast, the policies of the San Francisco County CWS agency require social workers to request law enforcement assistance only in situations involving allegations of sexual or severe physical abuse and suggest that law enforcement may conceivably be involved when serving a court-issued entry order. Officials with the San Francisco CWS agency stated that they prefer to avoid involving law enforcement, if possible, because doing so can impair their ability to engage some families in future services.

Although this preference may be permissible, we noted several instances in our review that may indicate a breakdown in communication between San Francisco local law enforcement and the CWS agency. In particular, we found five referrals for which law enforcement was aware of critical information, including allegations of child maltreatment, but did not share this information in a timely manner with the agency. Two of these incidents related to arrests made by law enforcement. In the first incident, which took place more than four months before the CWS referral report, a teenager was arrested by law enforcement because of a physical altercation with his caretaker. In another incident, a child witnessed domestic violence between the child's adult siblings that resulted in an arrest. We did not find any indication that law enforcement had reported either of these incidents to the county CWS, and the agency did not become aware of the incidents until someone else called in a referral.

In a third referral, which was reported 11 days after the corresponding incident, a teenager called law enforcement while being physically abused by her mother. Police did not arrest the mother but suggested that the girl leave the house and go for a walk to calm down. The child left and spent a couple of days with a former foster parent. The CWS agency became aware of the incident only after the mother later attempted suicide and a therapist submitted a required report to the agency. The lack of communication between CWS and law enforcement in this instance is particularly disconcerting because the child could easily have returned home later that night and been at risk of further physical abuse. In a fourth referral, a 14-year-old allegedly stole firearms from his mother. The San Francisco County CWS agency called law enforcement before the in-person investigation requesting information regarding the firearms and law enforcement's investigation. However, in this case law enforcement did not respond until 11 days later after CWS had conducted an in-person investigation. This delay could have placed the social worker or family members in harm's way. In a final example, the person making the report stated that law enforcement responded to an incident that took place between a mother and an 11-year-old a week before the current referral. According to the person making the report, law enforcement determined that the children residing in the home were well cared for but expressed concern about them not attending school. We did not find any indication that law enforcement reported the original incident to CWS or that the investigating social worker attempted to contact law enforcement despite being aware of its prior involvement.

Although the San Francisco County CWS agency indicated that it has a positive relationship with local law enforcement, the abovementioned instances indicate that it may not be getting

*We found five referrals for which the San Francisco local law enforcement was aware of critical information, including allegations of child maltreatment, but did not share this information in a timely manner with the CWS agency.*

### State Law Regarding Cooperative Agreements With Local Law Enforcement

“The Legislature intends that in each county the law enforcement agencies and the county welfare or probation department shall develop and implement cooperative arrangements in order to coordinate existing duties in connection with the investigation of suspected child abuse or neglect cases.”

Source: California Penal Code, Section 11166.3 (a).

the information it needs from law enforcement, which could result in placing children unnecessarily at risk. Unlike the Butte and Orange County CWS agencies, the San Francisco County CWS agency does not have a formalized cooperative agreement with its local law enforcement. Therefore, as encouraged by state law (see the text box), a cooperative agreement with local law enforcement that formalizes expectations and coordination appears warranted.

We also assessed whether the county CWS agency should have requested law enforcement assistance in situations where law enforcement was not otherwise involved. We found only one instance in which we believe the agency should have involved law enforcement in its investigation but did not. The Butte County CWS agency received a report alleging that an adult male was providing drugs and sexually abusing a 13-year-old girl who had an extensive CWS history and no active caretaker. The CWS agency assigned this referral a 10-day response, preparing no hotline tool to justify this delay. Despite being given two potential locations to search for the girl, the agency visited only the child’s school (to which she was truant) and a prior caretaker who did not know the exact address of her whereabouts but provided a reasonable description of an additional place to search. The agency made a required report to law enforcement upon receiving the allegation but made no other effort to involve law enforcement in its investigation. After further unexplained delays in the CWS agency response and an arguably minimal effort to locate the child, the referral was closed. Justification for closure of the referral was that social workers were not able to find the girl and that the girl had previously refused CWS services. The Butte County CWS agency admitted that a Structured Decision Making (SDM) hotline tool was required for this referral but was not completed and that additional efforts to locate the child should have occurred up to and including the possible involvement of law enforcement.

### ***Variations in Levels of Law Enforcement Involvement in Child Removals Reflect Acceptable Differences in County Policies***

Similar to the varying county policies regarding CWS investigations, county policies regarding the extent of law enforcement involvement when removing children from the home also vary. We examined the prevalence of law enforcement involvement in 20 removals reviewed from each county by identifying who was present. In keeping with its propensity to conduct joint investigations with law enforcement, the

Butte County CWS agency had the highest occurrence of removals with both CWS and law enforcement personnel present, as indicated in Table 10. However, more than half of these removals were a result of law enforcement requesting immediate assistance from CWS. The Orange County CWS agency had a much higher number of removals that occurred at a court hearing after CWS investigated a referral, decided to leave the children in the home, and requested a court hearing. This agency rarely removed a child on its own, and when it did, it contacted law enforcement and obtained their concurrence, in accordance with its policy. The other two county CWS agencies do not have a similar policy.

**Table 10**  
Summary of Who Was Present During Child Removals

CIRCUMSTANCES OF REMOVAL	COUNTY CHILD WELFARE SERVICES (CWS) AGENCY			TOTAL
	BUTTE	ORANGE	SAN FRANCISCO	
Removed with both CWS and law enforcement present	12	6	5	23
Removed by CWS alone	7	4	10	21
Removed by law enforcement alone	1	1	3	5
Removed at a court hearing	0	9	2	11
<b>Total removals reviewed</b>	<b>20</b>	<b>20</b>	<b>20</b>	<b>60</b>

Source: California State Auditor's review of 20 removals each at the CWS agencies for Butte, Orange, and San Francisco counties.

The San Francisco CWS agency had the highest occurrence of removals in which CWS removed a child without law enforcement involvement, and it also had the highest number of instances in which law enforcement removed a child without consulting CWS. As discussed earlier, these results reflect differences in county policies and philosophies that appear to reflect the flexibility afforded to county administration of CWS programs.

***The Butte and San Francisco County CWS Agencies Did Not Always Comply With Requirements to Report Child Abuse and Neglect to Law Enforcement***

We found a few instances in which county CWS agencies did not comply with state laws that require them to report suspected child maltreatment to law enforcement (cross-report). State law requires that CWS provide a written report to local law enforcement within 36 hours for every known or suspected instance of child abuse or neglect, except in cases of general neglect or where the

risk to a child is solely related to a caretaker's incapacity from substance abuse. In our review of 40 referrals at each county, we found that the Orange County CWS agency reported all referrals as required. The San Francisco County CWS agency did not cross-report one referral to law enforcement that we determined was required. For this referral, the agency noted that the intake worker forgot to send the initial cross-report but indicated that law enforcement would not have wanted a subsequent report since the agency later ruled the referral was unfounded.

The Butte County CWS agency did not cross-report two referrals to law enforcement as required. One of these referrals alleged physical abuse of a child. At the time of the referral, the child was staying at a hospital in another county. Rather than file a report within 36 hours as required, the agency reported the incident to law enforcement five days later, after completing its investigation. In the second referral, the person making the report alleged severe neglect of a child. The Butte County CWS agency did not initially cross-report the referral to law enforcement as required, and it eventually determined this referral was unfounded and consequently made no subsequent report to law enforcement. Although we noted these errors and brought them to the attention of Butte and San Francisco County CWS agency management, these few instances do not appear to point to a systemic problem in need of further recommendation or follow-up.

### **To Varying Degrees, Each County CWS Agency We Visited Could Improve Its Internal Controls**

For each county CWS agency we visited, we identified management processes, which we refer to as *internal controls*, that the agency should improve; and we also identified best practices that other county CWS agencies may want to emulate. Internal controls are used to ensure that an agency meets its objectives, and they include the implementation of policies and procedures designed to provide reasonable assurance that the agency conducts a program in accordance with applicable laws and regulations. For the three agencies we visited, we examined their policies and procedures that related to receiving and investigating allegations of child maltreatment, assessing the immediate safety and ongoing risks to children, and making decisions to either remove children from their homes or allow them to remain with their families. We also examined how management within these agencies monitors how well CWS personnel carry out the policies and procedures of their respective agency.

### ***The Butte and San Francisco County CWS Agencies Need to Improve Their Policies and Procedures***

The process of the Orange County CWS agency for developing clear policies and procedures would benefit other county CWS agencies, including both the Butte and San Francisco County CWS agencies. The Orange County CWS agency maintains policies and procedures in an operations manual and updates them frequently. The agency has a designated unit charged with monitoring applicable statutory and regulatory changes and with having ongoing communications with management on what policies and procedures should be revised. This unit takes the lead in gathering relevant input, drafting the policy, obtaining feedback and management approval for revisions, and then disseminating these changes to agency personnel. Based on our review, we found that the policies and procedures of the agency appear robust and clear. They systematically detail each of the agency's major functions and, as indicated in the text box, generally follow a consistent pattern that communicates all necessary information well.

Unlike the Orange County CWS agency, the Butte and San Francisco County CWS agencies do not have designated personnel responsible for updating policies and procedures. We analyzed the policies and procedures of the Butte County CWS agency and found that they lack clear policy statements in some areas and generally lack a systematic description of the requirements for each functional area (for example, intake of allegations, investigation of referrals, removal of children from unsafe homes, and placement of children in new homes). In San Francisco, CWS managers and staff were frequently unable to locate specific policies or documentation regarding their operations, including the handling of referrals.

With inadequate communication of requirements, these agencies are at higher risk of having inconsistent practices among staff and limiting their ability to hold staff and managers accountable for completion of required activities. Management from both these CWS agencies acknowledged that their policies and procedures could be improved and agreed that they need to designate a person or unit to develop and maintain policies and procedures. The deputy director of the San Francisco County CWS agency indicated that the agency has already begun an overhaul of its policies and procedures using the policies and procedures of the Orange County CWS agency as a template with its permission.

#### **Pattern for Policies and Procedures of the Child Welfare Services Agency in Orange County**

Each major section of the operations manual contains descriptions of the following:

- Date of the policy and dates of all subsequent policy revisions
- Purpose of the policy
- Approval date and approving officer
- A description of the most recent policy revision
- Relevant background
- Links to the legal basis for the policy
- Definitions of terms
- The policy itself (visually delineated with titles and boldface descriptors in the margins)
- References to related policies and required forms

*Source: Orange County Social Services Agency, Children and Family Services Operations Manual.*

***The San Francisco CWS Agency Has No Quality Assurance Program, and the Butte and Orange County CWS Agencies Could Make Improvements to Their Quality Assurance Efforts***

Both the Butte and Orange County CWS agencies have designated units that monitor the quality of investigative and ongoing casework within their agencies. However, a comparison of the resources and practices of these two units shows that both agencies could improve their quality assurance units. The San Francisco CWS agency has not established a quality assurance unit responsible for monitoring whether agency personnel are effectively carrying out required activities. Consequently, its management does not receive the same level of detailed feedback that the management of the other two county CWS agencies receives and uses to continuously improve their respective agency's practices.

All county CWS agencies participate in the California Child and Family Review system (outcome review), a review process the California Department of Social Services (Social Services) uses to monitor the activities of county CWS agencies. The outcome review is a five-year cycle of regular activities focused on improving the safety and well-being of children and their families. These measurements use aggregate data, which can provide insight into the quality of social work in a county CWS agency but cannot necessarily detect all types of noncompliance or ineffective practices. Social Services supplements its outcome reviews with an online review of a sample of cases, but it does not conduct these reviews on a regular schedule, and the statewide sample size is too small to act as an adequate substitute for ongoing monitoring that the management of county CWS agencies should be doing. Further, although each county CWS agency we visited requires supervisors to review key documents and decisions of the social workers they oversee, management still needs a mechanism to know if these supervisory reviews are being performed appropriately. Thus, we expected to find, at least at some level, ongoing monitoring of the quality of casework.

***We expected to find, at least at some level, ongoing monitoring of the quality of casework.***

In Butte County, the county CWS agency recently established a one-person quality assurance unit that has developed, in collaboration with management and social workers, a robust set of tools to review the quality of referral intake and ongoing case management. According to the director who oversees the agency, it assigned a senior social worker to be a quality assurance specialist in January 2013 because, after receiving the results of an earlier consultant study, "it was evident that more focused energy needed to be dedicated to regularly evaluating cases." In addition to developing the review tools, this specialist reported that she had completed approximately five referral intake reviews per month and a total of five more comprehensive case reviews as

of December 2013. The specialist indicated that she still needs to develop review tools for investigation and placement practices, and she acknowledged that the quality assurance unit may eventually require more staff. The director stated that they would like to review more referrals and cases to improve practice within the agency. The agency has plans in its proposed 2014–15 budget to request additional personnel for the quality assurance unit.

In contrast, the county CWS agency in Orange County has a six-member quality assurance unit, which, in addition to performing random case reviews, serves a number of other roles, including completing child death reviews, investigating community complaints, and coordinating federal and state audits. As indicated in the Appendix, the Orange County CWS agency had over seven times the budget of the Butte County CWS agency and six times the caseload in fiscal year 2012–13. Consequently, the quality assurance unit in Orange County, which was formed in 1997, is more robust than what might be found in a smaller county such as Butte County. In fact, in December 2012, Orange County moved supervision of its quality assurance unit from its CWS agency to a quality support team that the county's social services agency oversees.

Despite this level of organizational development, the quality assurance unit in Orange County does not yet use referral and case review tools like those in Butte County. The manager of the quality support team stated that they have had a goal to develop review tools for program supervisors and managers to monitor their casework and also for the quality assurance unit to use on a quarterly or semiannual basis. In November 2013 the quality assurance unit completed development of a draft tool for reviewing certain types of ongoing cases; however, the unit still needs to vet this tool with program staff. By spring 2014 the unit plans to complete development of at least two review tools—one for intake and investigations and one for ongoing cases. Developing and then using these tools consistently will allow Orange County's quality assurance unit to regularly report to agency management on whether the quality of social work in the agency is improving or needs attention.

Despite higher per-case funding than the other two agencies we reviewed (as described in the Appendix), San Francisco does not currently have a quality assurance unit responsible for evaluating and monitoring organizational compliance with or the overall effectiveness of its policies. The deputy director of the CWS agency in San Francisco explained that at one time the agency had a quality assurance unit but that it was dissolved, apparently as a result of budget cuts. The deputy director also stated that she and other CWS officials are currently attending trainings on

***San Francisco does not currently have a quality assurance unit responsible for evaluating and monitoring organizational compliance with or the overall effectiveness of its policies.***

continuous quality improvement sponsored by Social Services. These trainings and her own observations have convinced her that the San Francisco CWS agency could benefit from having a unit that conducts case reviews and provides feedback on how well policies are being implemented. As a result, the deputy director stated that the agency is developing a quality assurance unit with the help of a program manager who was part of the former quality assurance unit.

### **The County CWS Agencies We Visited Are in Different Stages of Implementing Best Practices for the Protection of Children**

The three CWS agencies we visited have identified and begun implementing best practices for the protection of children in their counties. As discussed in the Introduction, child welfare workers and community partners have deemed the then-pilot strategies of Standardized Safety Assessments, Differential Response, and Permanency and Youth Transition to be best practices that improved their ability to achieve positive outcomes.<sup>13</sup> According to the pilot project report, these three pilot strategies were selected in part because they were research-based or already-proven practices that had been implemented in other states and, in some cases, certain counties in California. The report cited research that these approaches were likely to achieve positive improvement in children's safety, permanency, and well-being. Officials at Social Services and the three county CWS agencies we visited agreed that these strategies, in addition to a more recent safety model, were best practices.

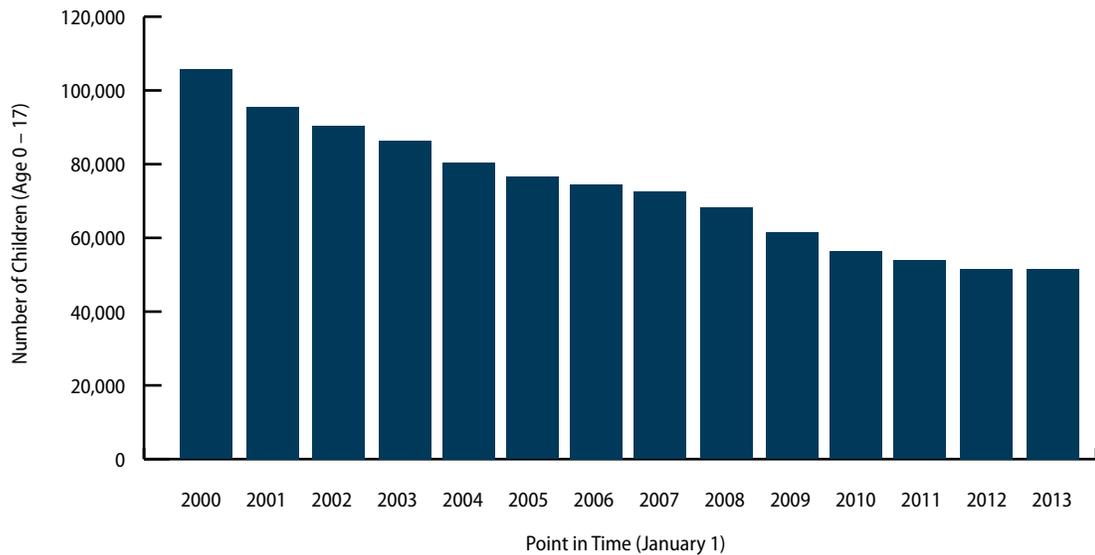
The annual number of children removed from their homes and placed within California's CWS system decreased over the last decade from roughly 35,000 to 31,000. Social Services cited studies that found that children left in their homes do better than comparably maltreated children placed in foster care. The chief of Social Services' Child Protection and Family Support Branch stated that the "research is clear that the removal of a child from his or her home is a traumatic event, and that CWS's focus is trying to work with children and families, providing services to attempt to resolve the issues that put children at risk of abuse and neglect." Consequently, California county CWS agencies have been implementing new strategies to deal with child maltreatment, including the best practices identified in the 2003 pilot project report. Combined with efforts to help children exit the CWS system to permanent homes (via reunification and adoption),

*California county CWS agencies have been implementing new strategies to deal with child maltreatment, including the best practices identified in the 2003 pilot project report.*

<sup>13</sup> Permanency and Youth Transition encompasses a number of reform efforts, including Team Decision Making and parent mentors, which are discussed in more detail in this chapter.

the decrease in entries into the CWS system has dramatically reduced the number of children in CWS placements, as indicated in Figure 6.

**Figure 6**  
**Number of Children in Child Welfare Services Placements**  
**2000 Through 2013**



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

### ***Structured Decision Making***

As shown in Table 11 on page 59, all three CWS agencies have been using Structured Decision Making (SDM) for their safety assessments for a number of years. The 2003 pilot project report cited a study conducted in another state that found that locations using SDM were significantly more likely to effectively screen out referrals, identify safety-related issues, and develop corresponding safety plans, and they were significantly less likely to see a valid repeat referral. In its most recent *Annual Progress and Services Report*, Social Services stated that the tools that make up SDM promote a uniform practice of intake assessments by increasing consistency and accuracy in emergency response among child welfare staff within and across the State. Even so, as we discuss in Chapter 1, all of the county CWS agencies we visited could improve the consistency and accuracy with which they use these tools.

### **Team Decision Making Meetings**

In 2003 and 2004 the three county CWS agencies implemented another best practice, Team Decision Making meetings. In the pilot project report, Team Decision Making was identified as a best practice under the Permanency and Youth Transition category. According to the report, social workers found that these meetings, which involve families and other support system members participating in a dialogue about a child's needs, result in greater cooperation from families and more viable placement options for children. Social workers also reported that Team Decision Making meetings stabilized troubled placements when the meeting process facilitated communication and conflict resolution.

The primary goal of Team Decision Making is to make the best possible decision with families about their children's placement.

In these meetings, child welfare staff, family, family supports, service providers, and community members work together to assess a family's strengths and needs, make critical placement decisions, and develop specific safety plans for children at risk. Although the goal of these meetings is to reach consensus regarding whether a child is to be moved, the agency maintains responsibility for final decision making while inviting and welcoming input from family and community partners. As shown in the text box, Team Decision Making meetings can be used at different decision-making points in the CWS process.

#### **Decision Points Addressed by Team Decision Making Meetings**

- Possible removal of a child from the home.
- Possible placement change.
- Implementation of a permanency plan (reunification, adoption, guardianship).

Source: Annie E. Casey Foundation, *Four Approaches to Family Team Meetings*.

In its most recent *Annual Progress and Services Report*, Social Services states that Team Decision Making is an effective and common method for improving placement stability. The report further states that Team Decision Making meetings help ensure that community and family support systems are in place at the inception of a CWS case and that safety plans are in place for the family. Moreover, Social Services reports that completing these meetings at placement changes ensures that children are placed in the least restrictive and most appropriate setting, reduces unnecessary placement moves for children, and assists families with the needed support to reunify successfully. As a possible result of the implementation of these meetings, placement stability (measured as the number of children who have experienced two or fewer placements while in CWS care) increased statewide from 60 percent in 2004 to a high of 70 percent in 2012.<sup>14</sup>

<sup>14</sup> These percentages combine three separate groups that Social Services reports on separately. Following Social Services' methodology, this calculation excludes children who were in a CWS placement for fewer than eight days.

**Table 11****Summary of Best Practices Implemented by Butte, Orange, and San Francisco County Child Welfare Services Agencies**

COUNTY	BEST PRACTICES AND YEAR IMPLEMENTED				
	STRUCTURED DECISION MAKING	TEAM DECISION MAKING	DIFFERENTIAL RESPONSE	PARENT MENTORING/ PEER PARENTS	SAFETY ORGANIZED PRACTICE (SOP) MODEL
Butte	2005	2004	2014*	2011	2010
Orange	1999	2004	2007	2007	2013 <sup>†</sup>
San Francisco	2007	2003	2009	2005	2011

Sources: Interviews with and documentation obtained from the child welfare services agencies for Butte, Orange, and San Francisco counties.

\* Butte County had a Differential Response program from 2005 through 2007. The program formally ended in 2008 because of reduced overall funding in child welfare services in Butte County. However, Butte County officials indicated that new funding has been identified and the program is being implemented in 2014.

<sup>†</sup> Although Orange County has no formalized plan to implement SOP agencywide, in October 2013, Orange County began monthly SOP training for 60 supervisors and social workers who work directly with its client families. This is a 12-month module that is scheduled to be completed in October 2014.

### ***Differential Response***

All three county CWS agencies are now using Differential Response, a strategy that allows a CWS agency to respond more flexibly to reports of child abuse or neglect. Differential Response has three referral paths, which are assigned by the social worker based on information taken from the initial report:

- Path 1—Community response: This response is selected when a family is referred to CWS for child maltreatment but the initial assessment indicates that although the family is experiencing problems, the allegations do not meet statutory definitions of abuse or neglect. Families designated for this response path are linked to voluntary services such as counseling, parenting classes, or other supportive options to strengthen the family.
- Path 2—CWS and agency partners response: This response may be selected when allegations meet statutory definitions of abuse and neglect at the low to moderate risk level. Assessments indicate that with targeted services a family is likely to make needed progress to improve child safety and mitigate risk. This path emphasizes teamwork among CWS and interagency or community partners to provide a multidisciplinary approach in working with families.
- Path 3—CWS response: This response is chosen when the initial assessment indicates that the child is not safe. With the family's agreement whenever possible, actions must be taken to protect the child. Court orders and law enforcement may be involved. This path is most similar to the traditional CWS response to child maltreatment.

*Each of the CWS agencies has parent mentors who have successfully reunified with their children and who subsequently work one on one with parents currently involved in the CWS system.*

The pilot project report cites research that families receiving Differential Response services were more likely to be receptive to and engaged in services and had lower recidivism rates and fewer subsequent allegations of child abuse and neglect; in addition when subsequent reports were made, the reports were less severe. In its most recent *Annual Progress and Services Report*, Social Services stated that Differential Response has contributed to reducing the recurrence of maltreatment by providing earlier and more comprehensive intervention services by both CWS agencies and community-based partners.

### ***Parent Mentoring and Peer Parents***

All three CWS agencies identified using parent mentors as a best practice. The pilot project report also identified parent mentors as an additional approach in the Permanency and Youth Transition category. Each of the CWS agencies has parent mentors who have successfully reunified with their children and who subsequently work one on one with parents currently involved in the CWS system. The San Francisco CWS agency began using parent mentors in 2005, the Orange County CWS agency in 2007, and the Butte County CWS agency in 2011. The agencies indicate that parent mentors have had firsthand experience with CWS and have exhibited exceptional qualities in their own efforts to reunify successfully with their children.

San Francisco's CWS agency has parent mentors that it refers to as *peer parent advocates*. These individuals advocate for parents currently involved in the CWS system and attend court hearings and Team Decision Making meetings. In addition, the parent mentors provide information about community resources to the parents with whom they are working. In the Butte County CWS agency, parent mentors work directly with parents in Family Treatment Court who may have challenges in understanding or successfully navigating the requirements of the CWS system and learning to parent while in recovery from drug addiction. The Orange County CWS agency's most recent *Annual System Improvement Plan Progress Report* identified the use of parent mentors as a means of improving its reunification efforts.

### ***Safety Organized Practice***

One of the more recent efforts to reform child welfare work is the Safety Organized Practice model. Social Services reported that California has recently begun to work with this new approach to family engagement, which has been adopted by numerous CWS agencies throughout the country. Social Services indicated that

California's regional training academies are conducting training and facilitating the implementation of Safety Organized Practice. The Safety Organized Practice model consists of different strategies to improve child safety by involving the children, their families, social workers, and other parties in decision making. Safety Organized Practice objectives include:

- Engagement: To create a shared focus to help families, social workers, and others work together to create safety for children.
- Critical thinking: To help everyone involved in a family's life consider the complicated and confusing information and sort it in a way that makes sense to all involved in the case.
- Enhancing safety: To provide a path for families, social workers, and others to create a careful, thoughtful, and lasting plan to ensure that children remain safe over time.

Social Services believes county CSW agencies receive two primary benefits from implementing the Safety Organized Practice model. The first is a common understanding among child welfare workers, families, and the extended community as to what the dangers and risks are that should bring CWS agencies into contact with families, as well as the protective capacities, family strengths, and natural supports that can create safety for children in the home. The second is training, coaching, and technical assistance in the application of research-based tools to enhance the consistency, validity, and equity of key CWS decisions. Social Services reported that as of August 2013, 42 of California's 58 counties had implemented Safety Organized Practice and seven counties had begun implementing it; the remaining nine counties had not yet begun implementation.

The Butte County CWS agency began using the Safety Organized Practice model in 2010, and the San Francisco CWS agency began using it in 2011. The Orange County CWS agency began Safety Organized Practice training for some of its supervisors and social workers in October 2013 and is scheduled to complete it in October 2014. At the Butte County CWS agency, its facilitators use Safety Organized Practice as a framework for Team Decision Making meetings. In addition, according to an administrative analyst in that agency, its goal is to use Safety Organized Practice tools to gather the information to be included in SDM assessments. When asked if there was any monitoring mechanism to determine positive outcomes attributable to this model, she stated that monitoring outcomes is challenging because many aspects of this model are used throughout the life of the case. She further stated that some aspects of Safety Organized Practice usage are monitored

*As of August 2013, 42 of California's 58 counties had implemented Safety Organized Practice and seven counties had begun implementing this model, which consists of different strategies to improve child safety by involving several parties in decision making.*

by supervisor case conferences, SDM usage statistics, and Team Decision Making meeting records, but it is difficult to pinpoint the exact effect of using the Safety Organized Practice model.

As county CWS agencies adopt this new model and continue to use strategies that were part of previous trends within the CWS system, the results of our review indicate that they should not neglect the fundamental management processes of developing clear policies and procedures, having supervisors perform ongoing reviews of staff work, and establishing mechanisms to monitor the quality of staff and supervisor performance. These key practices will not only help county CWS agencies comply with applicable requirements but will help them manage the organizational change that occurs when adopting new methods and models.

### **Recommendations**

To improve its coordination and communication with local law enforcement, the San Francisco County CWS agency should consider entering into a memorandum of understanding with the applicable law enforcement agency that delineates how the two agencies will share information and assist each other in responding to child maltreatment.

To ensure that they provide clear, up-to-date guidance to their social workers, the CWS agencies of Butte and San Francisco counties should designate specific personnel to stay informed of relevant statutory, regulatory, and needed practice changes and to ensure that corresponding updates are made to their policies and procedures.

To ensure that its social workers and supervisors are performing required activities in a timely and effective manner, the San Francisco County CWS agency should follow through on its plans to develop a quality assurance unit. The unit should regularly review and report to management on the degree of compliance with, and effectiveness of, the agency's policies and procedures.

To promote the consistent application of agency policies and procedures, and to provide a consistent framework for its reviews, the quality assurance unit that monitors the Orange County CWS agency should complete its plans to develop and regularly use tools for examining the quality of investigative and ongoing casework.

To be able to review regularly more referrals and cases, the Butte County CWS agency should consider adding additional staff to its quality assurance function.

To promote continued improvement in the CWS system, Social Services should encourage each county CWS agency to designate personnel to update regularly their policies and procedures, to include a detailed description of the need for ongoing supervisory reviews of key aspects of their respective service processes and incorporate that description into their policies and procedures, and to designate personnel to perform regular quality assurance reviews. Social Services should ask each county CWS agency to report to Social Services on the status of these efforts within 60 days, six months, and one year from the publication of this audit report.

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: April 8, 2014

Staff: Benjamin M. Belnap, CIA, Audit Principal  
Sharon Best  
David J. Edwards, MPPA  
Brett D. Noble, MPA  
Scott R. Osborne, MBA  
Scilla M. Outcault, MBA  
Mark Reinardy, MPP  
Erin Satterwhite, MBA

Legal Counsel: Scott A. Baxter, JD  
Richard B. Weisberg, JD

For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at (916) 445-0255.

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## Appendix

### **CHILD WELFARE SERVICES EXPENDITURES FOR BUTTE, ORANGE, AND SAN FRANCISCO CHILD WELFARE SERVICES AGENCIES**

Tables A.1 through A.3 on the following pages display fiscal year 2010–11 through 2012–13 expenditures on child welfare services (CWS) administered by the county CWS agencies we visited: Butte County, Orange County, and San Francisco County. As identified in the Introduction to this report, the key services CWS agencies provide include emergency response, family maintenance, family reunification, and permanent placement. Each of these categories, as well as staff development, is included in tables A.1 through A.3. We also separately account for expenditures related to guardianship, which includes children who have exited the juvenile court dependency system and have entered into a legal guardianship.

Because our audit focuses on activities that occur before children are placed into foster care or made available for adoption, the expenditures shown in the tables do not include direct payments made to out-of-home providers (for example, foster family agencies, foster family homes, and group homes). Additionally, as discussed in the Introduction, in fiscal year 2011–12, there was a change to the funding method for some local government services, including CWS. This change, referred to as the 2011 Realignment (realignment), resulted in a shift in funding from the State's General Fund to the counties through the State's Local Revenue Fund 2011 starting in fiscal year 2011–12. We note this change in funding in the tables.

As indicated in Table A.1, Butte County's total expenditures decreased from a high of \$11.45 million in fiscal year 2010–11 to a low of \$9.6 million in fiscal year 2012–13, representing a 16 percent decrease. However, over this same time period, Butte County also experienced a 26 percent decrease in its caseload.

**Table A.1**  
**Butte County Child Welfare Services Expenditures**

	FEDERAL	STATE	COUNTY	TOTAL	CASELOAD
<b>Fiscal Year 2010–11</b>					
Emergency response	\$1,618,638	\$792,998	\$409,094	\$2,820,729	231
Family maintenance	722,206	565,804	189,197	1,477,207	156
Family reunification	1,293,853	854,711	324,591	2,473,155	249
Permanent placement	2,248,367	1,464,115	556,022	4,268,503	426
Staff development	250,105	94,787	41,742	386,634	
Guardianship	1,459	22,606	0	24,065	
Other	0	0	0	0	
<b>Totals</b>	<b>\$6,134,628</b>	<b>\$3,795,020</b>	<b>\$1,520,646</b>	<b>\$11,450,294</b>	<b>1,062</b>

	FEDERAL	2011 REALIGNMENT*	COUNTY	TOTAL	CASELOAD
<b>Fiscal Year 2011–12</b>					
Emergency response	\$1,541,831	\$757,093	\$390,045	\$2,688,969	211
Family maintenance	754,614	562,461	191,162	1,508,237	149
Family reunification	1,234,952	789,587	307,312	2,331,851	222
Permanent placement	2,004,664	1,262,418	491,341	3,758,423	354
Staff development	423,132	121,252	51,901	596,285	
Guardianship	5,932	19,119	0	25,051	
Other	0	0	0	0	
<b>Totals</b>	<b>\$5,965,126</b>	<b>\$3,511,930</b>	<b>\$1,431,761</b>	<b>\$10,908,817</b>	<b>936</b>

	FEDERAL	2011 REALIGNMENT*	COUNTY	TOTAL	CASELOAD
<b>Fiscal Year 2012–13</b>					
Emergency response	\$1,397,128	\$636,588	\$341,666	\$2,375,381	180
Family maintenance	547,470	412,949	131,478	1,091,897	102
Family reunification	1,112,939	688,059	269,219	2,070,218	193
Permanent placement	1,831,566	1,109,629	434,168	3,375,363	311
Staff development	404,883	115,446	49,514	569,843	
Guardianship	17,874	71,979	47,663	137,516	
Other	0	0	0	0	
<b>Totals</b>	<b>\$5,311,861</b>	<b>\$3,034,649</b>	<b>\$1,273,708</b>	<b>\$9,620,218</b>	<b>786</b>

Source: California Department of Social Services and audited county expense claims.

Note: It was not possible to determine law enforcement's expenditure of state and federal funds for various actions, including the removal of children.

\* Assembly Bill 118 (Chapter 40, Statutes of 2011) realigned the funding for child welfare services and established the Local Revenue Fund 2011, which is used to reimburse the counties for activities previously reimbursed by the State.

## Orange County

As Table A.2 shows, similar to Butte County, Orange County's overall expenditures decreased from a high of \$80.6 million in fiscal year 2010–11 to \$75.2 million in fiscal year 2012–13, a 6.8 percent decrease over the period. Orange County's caseload experienced a 12 percent decline over that same period.

**Table A.2**  
**Orange County Child Welfare Services Expenditures**

	FEDERAL	STATE	COUNTY	TOTAL	CASELOAD
<b>Fiscal Year 2010–11</b>					
Emergency response	\$24,619,785	\$7,591,110	\$5,525,614	\$37,736,508	2,039
Family maintenance	5,505,146	3,963,719	1,239,922	10,708,787	882
Family reunification	6,323,919	4,318,468	1,676,747	12,319,135	1,048
Permanent placement	9,432,353	6,167,523	2,394,687	17,994,563	1,496
Staff development	1,172,241	308,903	127,547	1,608,691	
Guardianship	8,760	222,240	1,295	232,295	
Other	0	0	0	0	
<b>Totals</b>	<b>\$47,062,204</b>	<b>\$22,571,963</b>	<b>\$10,965,812</b>	<b>\$80,599,979</b>	<b>5,464</b>
<b>Fiscal Year 2011–12</b>					
	FEDERAL	2011 REALIGNMENT*	COUNTY	TOTAL	CASELOAD
Emergency response	\$24,297,228	\$7,155,507	\$5,374,005	\$36,826,740	1,894
Family maintenance	5,545,529	4,074,879	1,233,510	10,853,918	908
Family reunification	6,232,005	4,105,020	1,569,495	11,906,520	1,024
Permanent placement	8,545,498	5,365,546	2,051,438	15,962,483	1,338
Staff development	1,248,808	327,260	131,451	1,707,519	
Guardianship	134,110	299,686	18,199	451,995	
Other	0	0	455	455	
<b>Totals</b>	<b>\$46,003,179</b>	<b>\$21,327,898</b>	<b>\$10,378,553</b>	<b>\$77,709,630</b>	<b>5,163</b>
<b>Fiscal Year 2012–13</b>					
	FEDERAL	2011 REALIGNMENT*	COUNTY	TOTAL	CASELOAD
Emergency response	\$23,270,337	\$6,735,048	\$5,118,647	\$35,124,032	1,762
Family maintenance	4,978,294	3,566,987	1,092,338	9,637,619	792
Family reunification	5,974,406	3,928,978	1,490,686	11,394,071	960
Permanent placement	8,675,594	5,613,522	2,147,852	16,436,969	1,269
Staff development	1,697,989	433,170	176,632	2,307,791	
Guardianship	9,123	167,114	74,490	250,727	
Other	0	0	578	578	
<b>Totals</b>	<b>\$44,605,744</b>	<b>\$20,444,819</b>	<b>\$10,101,223</b>	<b>\$75,151,786</b>	<b>4,783</b>

Source: California Department of Social Services and audited county expense claims.

Note: It was not possible to determine law enforcement's expenditure of state and federal funds for various actions, including the removal of children.

\* Assembly Bill 118 (Chapter 40, Statutes of 2011) realigned the funding for child welfare services and established the Local Revenue Fund 2011, which is used to reimburse the counties for activities previously reimbursed by the State.

### San Francisco County

Unlike the other counties we visited, San Francisco County's overall expenditures increased by \$8.5 million during fiscal years 2010–11 through 2012–13, an 18 percent increase. This increase occurred despite a 16 percent reduction in caseload. According to the finance director of San Francisco's Human Services Agency, there are several reasons for the increase in expenditures. First, agencywide, there was a 6 percent reduction in the total workforce from fiscal years 2009–10 to 2010–11, the first year of our calculation. This reduction was followed by a corresponding 6 percent increase in total workforce over the two-year period from fiscal years 2011–12 to 2012–13. He explained that approximately \$2 million (23 percent) of the nearly \$8.5 million increase in expenditures was attributable to this increase in staffing levels. Further, he reported that approximately \$3.7 million (42 percent) was attributable to cost-of-living adjustments for staff, and \$2.3 million (26 percent) was attributable to increased agency overhead costs. The agency was able to sustain this expenditure increase because it increased the percentage of children eligible for federal funding from a low of 70 percent in September 2010 to a high of 80 percent in June 2013 and because it made efforts to use a new state program that provides state funding for young adults age 18 to 21 that are still in the CWS system.<sup>15</sup>

With this additional revenue, the San Francisco CWS agency had expenditure increases while its caseloads were declining. In fact, by fiscal year 2012–13, its expenditure per CWS case was \$32,399, more than double Orange County's \$15,712 expenditure per CWS case, and more than two-and-a-half times Butte County's \$12,246 expenditure per CWS case. With this level of funding, we believe the San Francisco CWS agency should be able to implement the organizational improvements we recommend in chapters 1 and 2.

<sup>15</sup> The Extended Foster Care Program was implemented in January 2012 and provided the San Francisco County CWS agency nearly \$1 million in fiscal year 2011–12 and \$2.3 million in fiscal year 2012–13.

**Table A.3**  
**San Francisco County Child Welfare Services Expenditures**

	FEDERAL	STATE	COUNTY	TOTAL	CASELOAD
<b>Fiscal Year 2010–11</b>					
Emergency response	\$6,820,022	\$2,164,906	\$1,490,841	\$10,475,769	374
Family maintenance	5,666,150	2,512,992	795,892	8,975,033	388
Family reunification	2,931,826	2,052,582	664,098	5,648,506	293
Permanent placement	10,022,815	6,943,431	2,246,498	19,212,744	992
Staff development	1,619,166	432,195	172,278	2,223,639	
Guardianship	0	421,543	15,244	436,787	
Other	0	0	0	0	
<b>Totals</b>	<b>\$27,059,978</b>	<b>\$14,527,649</b>	<b>\$5,384,851</b>	<b>\$46,972,478</b>	<b>2,047</b>
<b>Fiscal Year 2011–12</b>					
	FEDERAL	2011 REALIGNMENT*	COUNTY	TOTAL	CASELOAD
Emergency response	\$8,148,068	\$2,199,199	\$1,734,733	\$12,082,001	353
Family maintenance	5,019,735	3,282,855	905,936	9,208,525	404
Family reunification	3,204,826	2,085,848	712,258	6,002,932	280
Permanent placement	10,037,084	6,523,736	2,242,404	18,803,225	835
Staff development	2,149,807	545,714	236,901	2,932,422	
Guardianship	163,436	205,112	11,304	379,852	
Other	0	0	0	0	
<b>Totals</b>	<b>\$28,722,957</b>	<b>\$14,842,464</b>	<b>\$5,843,536</b>	<b>\$49,408,957</b>	<b>1,872</b>
<b>Fiscal Year 2012–13</b>					
	FEDERAL	2011 REALIGNMENT*	COUNTY	TOTAL	CASELOAD
Emergency response	\$10,201,485	\$2,671,859	\$2,177,528	\$15,050,872	364
Family maintenance	6,579,055	2,899,557	1,108,582	10,587,194	405
Family reunification	3,758,765	2,460,372	873,726	7,092,864	281
Permanent placement	9,940,219	6,586,315	2,360,014	18,886,548	662
Staff development	2,481,616	630,415	271,707	3,383,738	
Guardianship	195,400	245,665	24,967	466,032	
Other	0	0	0	0	
<b>Totals</b>	<b>\$33,156,541</b>	<b>\$15,494,184</b>	<b>\$6,816,524</b>	<b>\$55,467,249</b>	<b>1,712</b>

Source: California Department of Social Services and audited county expense claims.

Note: It was not possible to determine law enforcement's expenditure of state and federal funds for various actions, including the removal of children.

\* Assembly Bill 118 (Chapter 40, Statutes of 2011) realigned the funding for child welfare services and established the Local Revenue Fund 2011, which is used to reimburse the counties for activities previously reimbursed by the State.

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April 2014



STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

Ms. Elaine M. Howle, State Auditor\*  
California State Auditor  
555 Capitol Mall, Suite 300  
Sacramento, CA 95814

Dear Ms. Howle:

**SUBJECT: CHILD WELFARE SERVICES – THE COUNTY CHILD WELFARE SERVICES AGENCIES WE REVIEWED MUST PROVIDE BETTER PROTECTION FOR ABUSED AND NEGLECTED CHILDREN 2013-110**

This letter provides the California Department of Social Services' (CDSS) initial response to the California State Auditor's Office draft report entitled *Child Welfare Services – The County Child Welfare Services Agencies We Reviewed Must Provide Better Protection for Abused and Neglected Children*.

If you have any questions concerning the enclosed CDSS response, please contact me at (916) 657-2598 or Cynthia Fair, Audits Bureau Chief, at (916) 651-9923.

Sincerely,

WILL LIGHTBOURNE  
Director

Enclosure

\* California State Auditor's comment appears on page 75.

California Department of Social Services (CDSS)  
**RESPONSES TO AUDIT RECOMMENDATIONS**California State Auditor

Audit #: 2013-110

Audit Title: ***Child Welfare Services – The County Child Welfare Services Agencies We Reviewed Must Provide Better Protection for Abused and Neglected Children***Recommendation for Social Services:**Recommendation:**

*To promote continued improvement in the [Child Welfare Services] CWS system, Social Services should encourage each county CWS agency to designate personnel to regularly update their policies and procedures, include a detailed description of the need for ongoing supervisory reviews of key aspects of their respective service processes that is incorporated in their policies and procedures, and designate personnel to perform regular quality assurance reviews. Social Services should ask each county CWS agency to report to Social Services on the status of these efforts within 60 days, six months, and one year from the publication of this audit report.*

**CDSS Response:**

The findings contained within this report were in response to a Legislative request to the Joint Legislative Audit Committee asking that the California State Auditor (CSA) examine the policies and procedures of child welfare agencies when removing children from homes. Specifically the request was to determine when it is appropriate to take a child into protective custody in the absence of any laws being broken by a child's parents or guardians and to evaluate the procedures in place to oversee any "abuse of that power". The California Department of Social Services (CDSS) is pleased that the results of this CSA audit did not contain findings suggesting abuse of power by child welfare agencies.

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Agree with Recommendation/Anticipated Completion Date: July 2015.

The Department is supportive of the Auditor's suggestion that it work closely with county child welfare agencies to further improve quality assurance processes to continue to ensure the integrity of the system and support the safety of children across California.

By July 2014, CDSS will issue an All County Information Notice to remind counties of the benefits of conducting qualitative reviews of their programs beginning with emergency response hotline calls through permanency.

By July 2015, CDSS will:

1. Update the California Child and Family Service Review guides to include detailed information about their quality assurance activities including number of staff designated to do quality assurance and whether their county has existing policies and procedures that they monitor.
2. Develop a statewide case review process to provide for qualitative reviews of social work practices across counties.

In addition, the Department will

- 1) Continue to monitor county data specific to emergency response, investigation timeliness and abuse determinations and dispositions to identify trends that support further review and technical assistance; and
- 2) Continue to monitor county performance on recurrence of maltreatment or re-entry into foster care.

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## Comment

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

To provide clarity and perspective, we are commenting on the California Department of Social Services' (Social Services) response to our audit. The number below corresponds to the number we have placed in the margin of Social Services' response.

While our report does not explicitly refer to any instances of "abuse of power by child welfare agencies," we do describe on page 25 that social workers did not always complete the required safety assessment and when they did, the safety assessment was not always substantially consistent with the case history and the facts of the allegations. Specifically, as noted on page 26, we found two instances where the social worker based the decision to remove a child at least in part on safety threats that information in the case file did not support. Because the safety assessment is the main tool used to determine whether a child can safely remain in the home, failure to complete or accurately complete the assessment means that social workers could reach an improper conclusion in deciding whether to remove the child.

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April 2014



COUNTY OF BUTTE  
DEPARTMENT OF EMPLOYMENT AND SOCIAL SERVICES

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CATHI GRAMS

*Director and Public Guardian/Public Administrator*

P.O. Box 1649, Oroville, CA 95965

PHONE: (530) 538-7572 FAX: (530) 534-5745

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County of Butte  
Department of Employment and Social Services  
202 Mira Loma  
Oroville, CA 95965

March 27, 2014

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 Butte County. *The Child Welfare Services: The County Child Welfare Services Agencies We Reviewed Must Provide Better Protection for Abused and Neglected Children* (Audit 2013-110) audit report takes a constructive look at the practices related to the removal of children from their home utilizing seven separate objectives.

The Department of Employment and Social Services (DESS) is proud to be a partner in the service of its children and families with our State oversight agency, the California Department of Social Services (CDSS), our County oversight body, the Butte County Board of Supervisors, and the Bureau of State Audits (BSA). DESS prides itself on being a responsive, innovative and forward-thinking agency in its efforts to strengthen families and protect children from abuse and neglect. We strive to provide the highest caliber of services along with other County departments and community partners.

DESS generally agrees with the findings and recommendations of the BSA audit report. Our comments on specific items are enclosed. We appreciate the collaborative manner in which your staff conducted the work leading to this report. We welcome the opportunity to examine our practices and will work to implement positive changes, both those prescribed by the BSA and other efforts that are currently in the implementation or planning phase. If you have any additional questions, I can be reached at (530) 538-7891.

Sincerely,

(Original signed by: Cathi Grams)

Cathi Grams  
Director

Enclosure

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\* California State Auditor's comment appears on page 83.



**COUNTY OF BUTTE**  
DEPARTMENT OF EMPLOYMENT AND SOCIAL SERVICES

CATHI GRAMS

*Director and Public Guardian/Public Administrator*

P.O. Box 1649, Oroville, CA 95965

PHONE: (530) 538-7572 FAX: (530) 534-5745

**Butte County Response**  
**Audit No. 2013 -110**

**Chapter 1**

**Although the Counties We Visited Generally Attempted Timely In-Person Investigations, They Were Not Always Successful in Establishing Contact with Alleged Victims.**

If an initial attempt to visit a child is unsuccessful, (for example if the family is not at home), social workers would need to perform follow up visits to ensure that the children are safe. As stated in the report, "State laws and regulations do not address requirements for follow up attempts". The BSA applied a five business day standard (adopted from another county) to review the follow up efforts of social workers in Butte County. Butte DESS concurs with the recommendation that it develop a clear policy for how frequently social workers must follow up with alleged victims in the event that initial attempts at contact are not successful. We do not concur with the BSA's methodology of measuring our performance based on another county's policy where no clear definition exists in State law and regulation.

①

**RECOMMENDATIONS**

**To ensure that referral response decisions are accurate, the Butte County CWS agency should develop policies requiring a supervisory review of the hotline tool and a monitoring system to ensure the supervisory reviews are completed.**

Butte County Department of Social Services (DESS) agrees with this recommendation. The DESS has already begun the process of updating and revising existing policies to enhance the supervisory review process.

**To ensure that the statewide case management system contains accurate and complete information for each referral, the Butte County CWS agency should update its policies or otherwise provide clear guidance to social workers about the importance of ensuring that all alleged perpetrators, victims, and types of maltreatment are accurately recorded upon intake.**

Butte County DESS agrees with this recommendation.

**To ensure that social workers are making reasonable and timely efforts to make in-person contact with children who are allegedly being maltreated, the Butte County CWS agency should do the following:**

- **Develop clear policies for how frequently social workers must follow up with alleged victims in the event that initial attempts at contact are unsuccessful.**

Butte County DESS agrees with this recommendation.

- **Develop clear policies about the method and durations of social workers' attempts at making contact with hard-to-reach families, and clearly state under what circumstances a referral may be closed for lack of contact.**

Butte County DESS agrees with this recommendation.

**To ensure that all required SDM assessments are completed, the Butte County CWS agency should develop and implement clear guidance regarding which assessments are required in different situations.**

Butte County DESS agrees with this recommendation.

**To improve the timeliness and accuracy of SDM assessments, the Butte County CWS agency should ensure that their supervisors are reviewing assessments in a timely manner.**

Butte County DESS agrees with this recommendation. The DESS will enhance the existing policy regarding SDM assessments to ensure that they are completed and reviewed in a timely manner.

**To improve the timeliness of their supervisors' reviews, the Butte County CWS agency should develop time frames for supervisors' review and approval of assessments and monitor supervisors' compliance with those time frames.**

Butte County DESS agrees with this recommendation. Time frames for supervisory oversight will be added to the existing SDM policy.

**To improve the quality of the investigative information available to social workers, the Butte County CWS agency should expand on their investigative narrative templates to include fields such as relevant criminal history, substance abuse, or mental health concerns.**

Butte County DESS agrees with this recommendation. During the period of April 2011 to March 2013 examined during the course of this audit, the investigative narrative was revised multiple times. The current investigative narrative template includes relevant criminal history, substance abuse and mental health concerns. DESS currently has a team of social workers, supervisors and management that are revising the investigative narrative template to better incorporate safety organized practice and investigation outcome information.

**To ensure that required safety plans are created, the Butte County CWS agency should have supervisors review all safety assessments in a timely manner and verify that any assessments designating the need for a safety plan are accompanied by a written safety plan signed by the responsible parties.**

Butte County DESS agrees with this recommendation. Revision of the current policy will occur to include more clearly defined time frames for supervisory approval.

**To help strengthen safety plans to effectively mitigate safety threats, the Butte County CWS agency should ensure that supervisors are reviewing and approving all safety plans.**

Butte County DESS agrees with this recommendation. The existing policy will be updated to include specific expectations regarding supervisory review and approval of all safety plans.

**As part of their responsibility to help children be safe at all points during the investigation of a referral, the Butte County CWS agency should do the following:**

- **Vet temporary living situations and caregivers to the extent allowable under the law, including a review of information contained within the statewide CWS database.**

Butte County DESS agrees with this recommendation.

- **Perform statutorily-required background checks and inspections before allowing children to be placed in a home.**

Butte County DESS agrees with this recommendation. In April 2012, DESS developed a policy regarding Emergency Relative and Non-Related Extended Family Member Placements. This policy gives clear guidance to social workers regarding the statutorily-required background checks and inspections before allowing a child to be placed in a home during the course of a child being brought into protective custody. Additional training to social workers and supervisors will occur reiterating the policy.

## Chapter 2

### RECOMMENDATIONS

**To ensure that they provide clear, up-to-date guidance to their social workers, the Butte County CWS agency should designate specific personnel to stay informed of relevant statutory, regulatory, and needed practice changes and to ensure that corresponding updates are made to their policies and procedures.**

Butte County DESS agrees with this recommendation. DESS is seeking to add additional personnel to meet the need for increased policy/procedure management, legislative oversight and law changes as they relate to child welfare practice. If the requested positions are approved with the FY 2014/2015 budget, it is anticipated that the new positions will be filled in September 2014. With the addition of these positions, a designee will be appointed for all regulatory oversight as it relates to child welfare in Butte County. This designee will report to the management team.

**To be able to regularly review more referrals and cases, the Butte County CWS Agency should consider adding additional staff to its quality assurance function.**

Butte County DESS agrees with this recommendation. DESS agrees that additional staff to its Quality Assurance Unit is necessary and is evaluating the best way to accomplish this goal.

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## Comment

### **CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM THE BUTTE COUNTY DEPARTMENT OF EMPLOYMENT AND SOCIAL SERVICES**

To provide clarity and perspective, we are commenting on the Butte County child welfare services (CWS) agency's response to our audit. The number below corresponds to the number we have placed in the margin of Butte County CWS agency's response.

We appreciate that Butte County CWS agency agrees with our recommendation to develop clear policies for how frequently social workers must follow up with alleged victims in the event that initial attempts at contact are unsuccessful. If the agency had such a policy, we would have used its policy when evaluating its social workers. Because it did not, as stated on page 22, we evaluated follow-up efforts of Butte County social workers using a five-business-day standard.

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April 2014



**County of Orange**  
**SOCIAL SERVICES AGENCY**

888 N. MAIN STREET  
 SANTA ANA, CA 92701-3518  
 (714) 541-7700

**MICHAEL F. RYAN**  
 DIRECTOR

**VACANT**  
 CHIEF DEPUTY DIRECTOR

**CAROL WISEMAN**  
 DIVISION DIRECTOR  
 ADMINISTRATIVE SERVICES

**WENDY AQUIN**  
 DIVISION DIRECTOR  
 ADULT SERVICES &  
 ASSISTANCE PROGRAMS

**GARY TAYLOR**  
 DIVISION DIRECTOR  
 CHILDREN & FAMILY SERVICES

**NATHAN NISHIMOTO**  
 DIVISION DIRECTOR  
 FAMILY SELF-SUFFICIENCY

March 28, 2014

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

RE: State Audit of the Orange County Social Services Agency (OC SSA) completed by the California State Auditor as requested by the Joint Legislative Audit Committee

Dear Ms. Howle:

Orange County acknowledges your review and recommendations to improve the safety and protection of children in Orange County. The *Child Welfare Services: The County Child Welfare Services Agencies We Reviewed Must Provide Better Protection for Abused and Neglected Children* audit report provides a comprehensive review of the policies, procedures, and processes OC SSA follows for removing a child, assessing risk and safety, and utilizing local law enforcement.

We appreciate your highlighting a few of the best practices found in Orange County, particularly the development of a clear set of policies and procedures which govern our work, often reflecting best practice and exceeding what is required by regulations.

Finally, OC SSA is appreciative of the collaborative manner in which your staff conducted the review process. We respect your analysis of the work we do in Orange County to protect and serve children and families. Enclosed, please find our comments regarding the Audit recommendations. If you have additional questions, I may be reached at (714) 541-7773.

Sincerely,

Michael F. Ryan  
 Director

cc: Gary Taylor, Children & Family Services Division Director

\* California State Auditor's comment appears on page 93.

## County of Orange Response to State Auditor's Report

**CHAPTER 1****Recommendations:**

1.1 To ensure that referral response decisions are accurate, the Orange County CWS agency should ensure that all intake supervisors are trained on the use of the hotline tool and they are regularly reviewing their staff's use of this tool.

1.1 **OC SSA Response:** Structured Decision Making (SDM) is a standardized safety assessment methodology that uses tools and assessments to assist social workers in making decisions throughout child abuse cases. The SDM hotline tool is used by OC SSA's Child Abuse Registry (CAR) to structure the decision when determining if concerns rise to the statutory level of abuse and if so, whether the response should be immediately or within ten days.

SDM hotline tool training is an annual training provided to OC SSA's CAR program. In addition, all new employees receive training upon entry to the CAR program. While OC SSA had a 95% completion rate with 93% substantially accurate, there continues to be room for improvement. Per OC SSA policy, CAR supervisors are required to review social worker's use of the hotline tool. The CAR Program Manager will continue to review the SDM and CAR policies with social workers and supervisors at program and unit meetings to emphasize the importance of compliance. The CAR Program Manager will provide oversight of supervisor's regular review of social worker's use of the tool. OC SSA's Quality Support Team (QST) will conduct bi-annual reviews to monitor progress both with hotline tool usage and supervisor oversight.

1.2 To ensure that the statewide case management system contains accurate and complete information for each referral, the Orange County CWS agency should update its policies or otherwise provide clear guidance to social workers about the importance of ensuring that all alleged perpetrators, victims, and types of maltreatment are accurately recorded upon intake.

1.2 **OC SSA Response:** It is OC SSA's understanding that the term "referral form" references the Emergency Response Referral Information (ERRI) form and that the term "Intake" refers to the work of CAR staff. Auditors found errors on the ERRI form, which contains information entered into the case management system (CWS/CMS). Auditors cited errors to include CAR social workers entering incomplete documentation of all involved individuals (that is, victims or perpetrators) or an incorrect

### County of Orange Response to State Auditor's Report

category of alleged maltreatment. They concluded that discrepancies could lead to providing subsequent investigators with inaccurate or incomplete information. The auditors also found three instances where inaccuracies in the CAR screening files led to a later response time than was appropriate.

The CWS/CMS Manual for New Users outlines that the ERRI is used to convey information needed by the social worker investigating child abuse or neglect (i.e., reporter details, victim details, demographic information, etc.). While the ERRI is a tool to assist in investigating reports of abuse or neglect, it is not State mandated. OC SSA has chosen to develop an alternative face sheet used to gather similar referral information, rather than utilize the ERRI.

OC SSA has two Policy and Procedures (P&Ps) that address the importance of gathering accurate and complete referral information. OC SSA's policy on taking child abuse reports is based on guidance outlined in Division 31-105 and contained in OC SSA's P&P Child Abuse Registry.

It is important to note that CAR only has the information provided by the reporting party. During the course of a child abuse investigation, additional information regarding alleged perpetrators and victims often becomes available or changes as the investigation progresses. In addition, the types of maltreatment may change if new allegations are added during the course of the child abuse investigation. This may result in a discrepancy between the information initially provided by the reporting party to CAR. OC SSA's P&P Abuse Investigations-Practice Guidelines states that when preparing to investigate a child abuse referral, as applicable, the investigating social worker will review prior referrals and services to ensure they have all information pertinent to the case. Further OC SSA's P&P Abuse Investigations - Practice Guidelines outlines the need for the investigating social worker to update the referral information in CWS/CMS prior to referral closure when additional information is obtained.

OC SSA agrees that accurate documentation is critical and in an effort to provide additional guidance to CAR and ER social workers, Program Managers and supervisors will continue to review the applicable P&Ps with social workers at program and unit meetings. Program Managers and supervisors will provide oversight to monitor progress of accurate documentation.

## County of Orange Response to State Auditor's Report

1.3 To ensure that its social workers are following its policy regarding timely follow-up visits, the Orange County CWS agency should provide training or other clarification of its policy and have its supervisors regularly review whether their staff are complying with this requirement.

1.3 **OC SSA Response:** OC SSA Emergency Response (ER) social workers are required to complete in person visits when investigating a child abuse referral. Division 31 Regulations do not provide guidance on the frequency in which social workers must make follow-up attempts when unsuccessful in making actual contact. OC SSA policy requires follow-up visit attempts every five days. The auditors found instances where attempts within five days did not occur.

Social workers receive training on OC SSA's P&P Abuse Investigations-Practice Guidelines, which addresses follow-up visits. Current policy will be reviewed to determine if further modification is warranted. Social workers will continue to be informed of the importance of conducting and documenting follow-up visits at varying times and, if necessary, varying locations. QST will conduct bi-annual random reviews to monitor progress.

1.4 To improve the timeliness and accuracy of SDM assessments, the Orange County CWS agency should ensure that their supervisors are reviewing assessments in a timely manner.

1.5 To improve the timeliness of their supervisors' reviews, the Orange County CWS agency should more closely monitor supervisors' compliance with its existing policies setting a 30 day time frame for review and approval of assessments.

1.4 and 1.5 **OC SSA Response:** Safety assessments are an SDM tool social workers use when they are conducting an in-person investigation of a child abuse referral. Safety assessments structure the decision when determining whether a child may safely remain in the home with or without safety interventions or if the child must be removed from the home. Risk assessments are an SDM tool social workers use after a social worker conducts an in-person investigation but before the referral is closed. Risk assessments structure the decision when determining whether the risk of future maltreatment is enough to open a case.

SDM policy requires supervisory review and approval of safety and risk assessments within 30 days from the date the in which the social worker completes this tool. This includes supervisor review of the

### County of Orange Response to State Auditor's Report

investigation to ensure that accurate information is reflected in the assessments. The auditors found instances where assessments were not accurate and/or reviewed by supervisors timely.

Safe Measures is an analytic service utilized by OC SSA. Safe Measures helps improve effectiveness by taking data from our case management system (CWS/CMS) and turning it into useful reports. Safe Measures helps OC SSA identify gaps in practice, training needs, and evaluating data input into CWS/CMS. The Safe Measures application is available to staff to monitor compliance of risk and safety assessments.

Program Managers will review the SDM requirements with supervisors. Program Managers and supervisors will increase usage of Safe Measures to track and monitor assessments for compliance purposes. Program Managers will monitor supervisors' use of Safe Measures. OC SSA will work with Children's Research Center (CRC) to consider development of a tracking mechanism in Safe Measures to monitor the timeliness of supervisor review and approval. QST will conduct bi-annual random reviews to monitor both for accuracies in the assessments and timeliness of supervisor approval.

1.6 To ensure that required safety plans are created, the Orange County CWS agency should have supervisors review all safety assessments in a timely manner and verify that any assessments designating the need for a safety plan are accompanied by a written safety plan signed by the responsible parties.

1.7 To help strengthen safety plans to effectively mitigate safety threats, the Orange County CWS agency should ensure that supervisors are reviewing and approving all safety plans.

1.6 and 1.7 **OC SSA Response:** As indicated in the prior response, safety assessments require supervisory review and approval within 30 days from the date in which the social worker completes this tool. OC SSA policy requires safety plans under the following conditions: 1) when a safety threat is identified in the SDM safety assessment, 2) a safety intervention is specified in the safety assessment, and 3) a child will be left in the home. Safety plans are developed with the agreement of the parent(s). The purpose of the safety plan is to specify interventions that must be in place if a child is to be left in the home with or without further OC SSA intervention.

## County of Orange Response to State Auditor's Report

OC SSA identified safety plans as an area that required improvement prior to this audit and has taken action steps across the last year to help strengthen safety plans to effectively mitigate safety threats, including training social workers and supervisors, revising the policy, and modifying the tools. While OC SSA believes that social workers are consulting with supervisors regarding development of the safety plan, OC SSA will continue to emphasize the need for documentation of consultation, timely consultation, and greater oversight by supervisors. Training will continue to be provided in this area to both social workers and supervisors. OC SSA will continue to review this area, and if determined necessary, revise current practice and procedures in an effort to increase compliance. QST will conduct bi-annual random reviews to monitor this area both in regards to quality and timeliness of safety plans.

1.8 As part of its responsibility to help children be safe at all points during the investigation of a referral, the Orange County CWS agency should do the following:

1.8.1 Vet temporary living situations and caregivers to the extent allowable under the law, including a review of information contained within the statewide CWS database.

1.8.1 **OC SSA Response:** If parent(s) make a plan for an alternate caregiver to provide care for their child (ren) for the purpose of ensuring child (ren) safety, then it would be appropriate to run statutory permissible background checks on the alternate caregiver. While there is no statutory guidance on this issue, OC SSA recognizes this as a best practice and will develop policy to support it.

1.8.2 Perform statutorily-required background checks and inspections before allowing children to be placed in a home.

① 1.8.2 **OC SSA Response:** OC SSA is in agreement with the recommendation if "placed" means "assessing the appropriateness and safety of placing a child who has been detained or is a dependent of the court, in the home of a relative assessed pursuant to Welfare and Institutions Code § 309 or 361.4, or in the home of a Non-Related Extended Family Member (NREFM) assessed as described in Welfare and Institutions Code § 362.7 during an emergency situation." (§ 16504.5.)

### County of Orange Response to State Auditor's Report

It is OC SSA's current policy to perform all statutorily-required background checks and inspections before allowing children to be placed in a home. Program Managers will review this policy with social workers and supervisors and provide additional oversight. OC SSA's Quality Support Team (QST) will conduct bi-annual reviews to monitor progress.

## **CHAPTER 2**

### **Recommendations:**

- 2.1 To promote the consistent application of agency policies and procedures, and to provide a consistent framework for its reviews, the quality assurance unit that monitors the Orange County CWS agency should complete its plans to develop and regularly use tools for examining the quality of investigative and ongoing casework.
  
- 2.1 **OC SSA Response:** OC SSA appreciates the auditor's recognition of our effort and QST will continue to move forward with the development and implementation of tools to examine the quality and compliance of investigative and ongoing casework. Development and utilization of these tools will allow for self-evaluation at the program level. In addition, these tools will be utilized by QST to conduct, at minimum, bi-annual random reviews.

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## Comment

### **CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM THE ORANGE COUNTY SOCIAL SERVICES AGENCY**

To provide clarity and perspective, we are commenting on the Orange County child welfare services (CWS) agency's response to our audit. The number below corresponds to the number we have placed in the margin of Orange County CWS agency's response.

As described on page 36, our report refers to social workers performing statutorily required background checks before allowing children to be placed in locations other than licensed facilities, such as the homes of relatives or nonrelative extended family members. As a result, we conclude that the Orange County CWS agency agrees with our recommendation.

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April 2014

**City and County of San Francisco***Edwin M. Lee, Mayor***Human Services Agency**Department of Human Services  
Family & Children's Services*Trent Rhorer, Executive Director*  
*Sylvia Deporto, FCS Deputy Director*

March 28, 2014

Ms. Howle  
Lead State Auditor  
621 Capitol Mall, Suite 1200  
Sacramento, CA 95814

Dear Ms. Howle,

We appreciate the time and effort that was put forward by you and your staff in conducting this audit. We have reviewed the comments and recommendations contained in the draft report provided by your office. Enclosed please find Table 1A, San Francisco County's response to the report findings which incorporate the specific tasks that will be implemented to address the recommendations.

As discussed, we concur with the audit findings and have begun to put structures in place in order to improve the provision of services to the families and children we serve.

Last fall, the Family and Children's Services Division (FCS) of the San Francisco Human Services Agency (HSA), conducted an examination of its policies and procedures and concluded that an overhaul was needed to provide clear expectations and guidance to FCS staff. After examining the policies and procedures manuals of several counties we identified Orange County's manual as the one which would best fit San Francisco. Orange County graciously provided us with the template for their policies and procedures to use in the development of our county's manual.

We are currently in the process of establishing a Policy and a Quality Assurance Unit (Q.A.). Specifically we have submitted a supplemental budget request to the Mayor's Office to create a Policy Unit which will be responsible for developing and maintaining up-to-date policies and procedures for FCS. Additionally, they will be required to stay informed of relevant statutory, regulatory, and needed practice changes and to ensure that corresponding updates are made to all FCS policies and procedures. The Policy unit will also develop clear practice guidelines which will address the recommendations of this report.

Prior to 2009, FCS had a Q.A. unit responsible for ongoing monitoring and reviewing of staff compliance with Federal, State and Local policies and laws. Due to the severity of the local budget crisis, the unit was cut. We are currently in the process of re-establishing a new Q.A. unit which will be responsible for monitoring quality, accuracy and timeliness of assessments, visits, CWS/CMS input, supervisory oversight, and overall program improvement. Q.A. will develop monitoring tools and will provide ongoing compliance reports and findings to the management team.

The Policy and Q.A. units will report to one manager who will provide oversight to both units thus ensuring that new policies and procedures are incorporated into practice and monitored for timely and accurate compliance.

Accountability for all aforementioned practice changes and requirements will be addressed through the inclusion of expectations in annual performance appraisals for child welfare program directors, supervisors and staff. Performance standards will be integrated into the day-to-day supervision of staff in order to ensure ongoing practice improvement.

If you have any questions regarding our response, please feel free to contact me at (415) 558-2660.

Sincerely,

(Original signed by: Sylvia Deporto)

Sylvia Deporto  
Deputy Director  
Family & Children's Services Division  
Human Services Agency

Cc: Trent Rhorer, Executive Director  
Christiane Medina, FCS Program Manager

TABLE 1A San Francisco’s Response to State Audit Recommendations

<b>Improvement Area</b>	<b>State Recommendation</b>	<b>County Response</b>
<p>Ensure that referral response decisions are accurate.</p>	<p>The County should develop policies requiring a supervisory review of the hotline tool and a monitoring system to ensure that the supervisory reviews are completed.</p>	<p>County concurs with findings.</p> <p>The current hotline supervisor is undergoing extensive re-training in appropriate Penal codes, WIC code sections, CWS/CMS hotline documents, supervisor functionality, SDM hotline policy and tools.</p> <p>We recently changed the management oversight of the Hotline and Emergency Response functions. With the new Program Director in place, we will improve oversight of these program areas.</p> <p>Once the policy unit is established, policies and procedures will be developed requiring supervisory review of all hotline referrals.</p> <p>Once the Quality Assurance unit is established a monitoring system will be put in place to ensure compliance with new policies that require supervisory reviews to be completed timely and accurately for all hotline referrals.</p>
<p>Ensure that the CWS/CMS contains accurate and complete information for each referral</p>	<p>The County should update its policies or otherwise provide clear guidance to social workers about the importance of ensuring that all alleged perpetrators, victims, and types of maltreatment are accurately recorded upon intake.</p>	<p>County concurs with findings.</p> <p>Hotline staff recently received training in Penal Codes, WIC codes to improve their knowledge and understanding of allegations.</p> <p>The Policy Unit will update existing policies and develop relevant Quick guides for staff use.</p> <p>The manager over Q.A. will work with the FCS Training Coordinator to conduct mandatory training in the new policy and practice expectations.</p> <p>Q.A. will develop a monitoring system and tools for ongoing compliance monitoring.</p>

Improvement Area	State Recommendation	County Response
<p>To ensure that social workers are making reasonable and timely efforts to make in-person contact with children who are allegedly being maltreated</p>	<p>The County agency should do the following:</p> <ul style="list-style-type: none"> <li>▪ Develop clear policies for how frequently social workers must follow up with alleged victims in the event that initial attempts at contacts are unsuccessful.</li> <li>▪ Develop clear policies about the method and duration of social workers' attempts at making contact with hard-to-reach families, and clearly state under what circumstances a referral may be closed for lack of contact.</li> </ul>	<p>County concurs with findings.</p> <ul style="list-style-type: none"> <li>▪ The Policy Unit will develop and implement clear policies and procedures regarding agency expectations for reasonable and timely efforts for in-person contacts with children</li> </ul> <p>Guidelines will be developed and will include specific expectations for frequency, method, and quality of in-person contacts in the event that initial attempts at contacts are unsuccessful.</p> <ul style="list-style-type: none"> <li>▪ Guidelines will also be developed specifying the circumstances under which a referral may be closed for lack of contact.</li> </ul> <p>Q.A. will work with the FCS Training Coordinator to conduct mandatory training in the new policy and practice expectations. Q.A. will conduct quarterly reviews to ensure adherence with the new policies.</p>
<p>Ensure that all required SDM assessments are completed</p>	<p>The County should develop and implement clear guidance regarding which assessments are required in different situations.</p>	<p>County concurs with findings.</p> <p>The Policy Unit will develop and implement policies and procedures clarifying expectations on when and how to use SDM.</p> <p>The county will work with the Children's Research Center and the Bay Area Training Academy, to provide training and initial coaching, as needed, to ensure consistent use and completion of the SDM tool.</p> <p>Q.A. will develop a review system and tools for ongoing compliance monitoring.</p>

<b>Improvement Area</b>	<b>State Recommendation</b>	<b>County Response</b>
<p>Improve the timeliness and accuracy of SDM assessments</p>	<p>The County should ensure that their supervisors are reviewing assessments in a timely manner.</p>	<p>County concurs with findings.                      Develop policies, guidelines and training for supervisors on the accurate and timely use and review of SDM.                      Establish clear polices on timeframes for supervisory review of assessments.                      Q.A. will develop a monitoring system and tools to ensure supervisors are reviewing assessments in a timely manner and that the assessments are accurate.</p>
<p>Improve the timeliness of its supervisors' reviews</p>	<p>The County should develop time frames for supervisors' review and approval of assessments and monitor supervisors' compliance with those time frames.</p>	<p>County concurs with findings.                      In addition to developing policies and guidelines for the accurate use and review of SDM, the county will develop supervisory tools delineating required timeframes for review and approval of SDM assessments.                      Q.A. will develop a monitoring system to ensure that supervisors are reviewing and approving assessments within the required timeframes.</p>
<p>Improve the quality of the investigative information available to social workers</p>	<p>The County should expand on their investigative narrative templates to include fields such as relevant criminal history, substance abuse, or mental health concerns.</p>	<p>County concurs with findings.                      The county plans to revise the current investigative narrative template to allow for more thorough and complete documentation of assessments. The new narrative will include the recommended fields.                      Once completed, we will provide training for staff in the proper use and completion of the narrative. We will also establish clear policies and expectations for its use.                      Q.A. will conduct periodic reviews to ensure that quality narratives are being completed.</p>

<b>Improvement Area</b>	<b>State Recommendation</b>	<b>County Response</b>
<p>Ensure that required safety plans are created</p>	<p>The County should have supervisors review all safety assessments in a timely manner and verify that any assessments designating the need for a safety plan are accompanied by a written safety plan signed by the responsible parties.</p>	<p>County concurs with findings.</p> <p>The Policy Unit will develop clear policies and procedures regarding the use of safety assessments and plans. It will include supervisory expectations for the timely review of assessments, and their role in verifying that required safety plans are completed and signed by all responsible parties.</p>
<p>Strengthen safety plans to effectively mitigate safety threats</p>	<p>The County should ensure that supervisors are reviewing and approving all safety plans.</p>	<p>County concurs with findings.</p> <p>In addition to developing clear policies and procedures for the use of safety assessments and plans, Q.A. will conduct random audits to ensure that supervisors are providing thorough reviews. Additionally, Q.A. will develop tools to monitor the quality and appropriateness of safety plans in effectively mitigating safety threats.</p>
<p>Ensure children are safe at all points of the investigation of a referral.</p>	<p>The County should do the following:</p> <ul style="list-style-type: none"> <li>▪ Vet temporary living situations and caregivers to the extent allowable under the law, including a review of information contained within the statewide CWS database.</li> <li>▪ Perform statutorily-required background checks and inspections before allowing children to be placed in a home.</li> </ul>	<p>County concurs with findings.</p> <ul style="list-style-type: none"> <li>▪ County will review and revise current policies and procedures regarding requirements for ensuring child safety when making temporary living arrangements.</li> </ul> <p>County will clarify supervisory and worker expectations and institute quarterly case reviews to ensure that arrangements are done in accordance with the law.</p> <ul style="list-style-type: none"> <li>▪ County will review and revise current policies to emphasize the required background checks and inspections prior to placing a child with a relative or non related extended family member.</li> </ul> <p>Child welfare supervisors and staff along with the Licensing Unit will be provided with additional training and support to ensure compliance.</p> <p>Additionally, Q.A. will perform random quarterly reviews to make certain that staff and supervisors are adhering to the policies.</p>

<b>Improvement Area</b>	<b>State Recommendation</b>	<b>County Response</b>
<p>Improve its coordination and communication with local law enforcement</p>	<p>The County should consider entering into a memorandum of understanding with the applicable law enforcement agency that delineates how the two agencies will share information and assist each other in responding to child maltreatment.</p>	<p>County concurs with findings.</p> <p>FCS will develop an MOU with SFPD delineating how the two agencies will share information and assist each other in responding to child abuse investigations.</p> <p>The MOU will specify the specific procedures, processes and forms necessary on how we will collaborate to respond to child abuse investigations.</p> <p>HSA in conjunction with law enforcement will develop a training and implementation plan for the MOU and ensure that all child welfare workers and law enforcement officers are trained.</p>
<p>Ensure that child welfare staff is provided with clear, up-to-date guidance</p>	<p>The County should designate specific personnel to stay informed of relevant statutory, regulatory, and needed practice changes and to ensure that corresponding updates are made to their policies and procedures.</p>	<p>County concurs with findings.</p> <p>A new function of the Policy unit will be to review and analyze relevant, statutory, and regulatory laws and practice changes that are issued by CDSS in the form of All County Letters, All County Information Notices and All County Fiscal Letters.</p> <p>The Policy Unit will update existing policies and develop relevant guidelines for staff.</p> <p>Policy will work with the FCS Training Coordinator to conduct mandatory training on the new policy and practice expectations.</p> <p>Q.A. will develop a review system and tools for ongoing compliance monitoring.</p>

<b>Improvement Area</b>	<b>State Recommendation</b>	<b>County Response</b>
<p>Ensure that County social workers and supervisors are performing required activities in a timely and effective manner</p>	<p>The County should follow through on its plans to develop a quality assurance unit. The unit should regularly review and report to management on the degree of compliance with, and effectiveness of, the agency's policies and procedures.</p>	<p>County concurs with findings.</p> <p>Once we receive approval to hire staff, Q.A. will conduct random quarterly reviews and will monitor child welfare staff and supervisors for quality, accuracy and timeliness of assessments, visits, CWS/CMS input, supervisory oversight and other key areas of service delivery in accordance with FCS policies and procedures.</p> <p>Q.A. will provide ongoing reports to the management team addressing degree of staff compliance with policies and procedures. Q.A. will also provide recommendations for ongoing improvement.</p>