California State Auditor

BUREAU OF STATE AUDITS

Kern County:

Management Weaknesses at Critical Points in Its Child Protective Services Process May Also Be Pervasive Throughout the State

January 1998
97103

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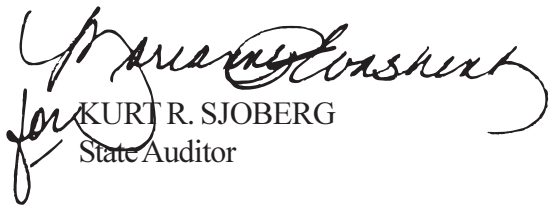
January 15, 1998 97103

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

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Kern County Child Protective Services system. This report concludes that the Kern County Department of Human Services' Family Preservation Bureau has management weaknesses at critical points in its child protective process. Additionally, although the Kern County Juvenile Court is generally effective in adjudicating cases of abuse or neglect, it could minimize the negative effects the dependency process has on children by better controlling continuances. Furthermore, a statewide survey of county child protective services agencies indicates that the problems Kern County is experiencing may be prevalent throughout the State. Finally, we find that the California Department of Social Services could help find solutions to these problems by improving its oversight of the State's child welfare services system.

Respectfully submitted,



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Kern County's Family Preservation Bureau:

- ☑ ***Does not always ensure that referrals of abuse or neglect are properly assessed and investigated promptly;***
- ☑ ***Has accumulated a backlog of almost 12,000 cases due to a dramatic increase in referrals and ineffective management; and***
- ☑ ***Lacks a systematic method to monitor and track caseloads.***

The Kern County Juvenile Court:

- ☑ ***Is generally effective in adjudicating cases, but could reduce the stress of the dependency process on children by limiting continuances; and***
- ☑ ***Does not have an information system to monitor its operations.***

The California Department of Social Services:

- ☑ ***Has not conducted timely compliance reviews of county child protective agencies;***
- ☑ ***Does not track the number of child deaths that occurred due to abuse and neglect; and***
- ☑ ***Has shown recent leadership in improving statewide child protective services.***

Results in Brief

The Kern County Department of Human Services' Family Preservation Bureau (department) and the Juvenile Court (juvenile court) of the Kern County Superior Court are responsible for providing protective services to children who are at risk of being abused or neglected by a parent or guardian. The California Department of Social Services (DSS) is responsible for supervising the statewide system of child welfare services, including child protective services. In our review of the department and the juvenile court, we identified problems at three points where critical decisions are made: in the department's emergency response to its allegations, in its investigation of these allegations, and in the juvenile court's administration of hearings. In addition, we noted that the DSS has only recently improved its efforts to monitor child protective services in the State.

In our review of the department, we found the following weaknesses:

- Its emergency response phone room staff do not always use established checklists to ensure proper decisions are made.
- Investigation unit staff do not always initiate or complete investigations promptly, obtain information from collateral contacts, complete risk assessments in determining the risk of future abuse or neglect, hold required strategy conferences between supervisors and staff when investigating a referral for a family previously investigated, or provide feedback to mandated reporters.
- The Court Intake, Family Maintenance, Family Reunification, and Permanent Placement sections do not always visit the abused or neglected children or the parents in accordance with timelines established by law.

These weaknesses have been caused in part by a dramatic increase in referrals over the past few years. However, the department's ineffective management of its operations is also a factor. For example, the department does not always provide prompt or effective supervisory reviews of its social workers'

performances. Further, the department has not established a systematic method of monitoring its employees' workloads, nor has it developed procedures for its employees to follow in providing child protective services.

We found that the juvenile court is generally effective in adjudicating the cases of abuse and neglect that the department brings to it. However, because it has only one judge to preside over contested cases, the juvenile court often continues hearings, which lengthens the time that minors must remain in a contested dependency proceeding. Lengthy proceedings may add to the degree of stress placed on minors by the dependency process. Furthermore, we found that the juvenile court does not have an information system to monitor its workload or actions and to determine how it is operating.

Our review also disclosed that the DSS has not always fulfilled all of its responsibilities in implementing and maintaining a statewide system of child protective services. Specifically, until fiscal year 1996-97, the DSS had not conducted timely compliance reviews of the counties' child protective services programs and did not ensure that those reviews included an evaluation of the counties' emergency response or administrative practices. We also noted that the DSS does not track the number of child deaths that occurred due to abuse and neglect. Without timely compliance reviews of county child protective services agencies, the DSS cannot be assured that children in the State are protected from abuse and neglect. Further, because the DSS does not obtain information regarding child deaths due to abuse and neglect, the DSS may not be able to identify county or systemic weaknesses that require regulatory or statutory change to properly address those weaknesses. Recently, the DSS has shown leadership in improving the child protective services program in certain areas, such as developing a research-based, statewide risk-assessment tool and establishing regional training academies.

However, the DSS needs to provide more guidance to counties that provide child protective services. As part of this audit, we surveyed all 58 counties in the State and found that many counties experience the same problems we identified in Kern County. For example, of the 46 counties responding, we noted the following:

- None of the counties used research-based risk assessments.

- Forty do not have quality assurance positions within their organizations to monitor the quality and effectiveness of the services they deliver.

- Forty have not identified outcomes by which to measure effectiveness.

- Fourteen have no method to monitor social worker workload.

- Only seven have developed caseload standards for social workers.

- Twenty-five do not have policies and procedures manuals for employees to follow in providing child protective services.

- Between 1994 and 1996, 295 children died as a result of abuse or neglect.

- Twenty do not review child death cases to determine if county policies or practices need to be revised.

Recommendations

To ensure that it provides prompt, effective child protective services, the department should:

- Ensure that its supervisors provide prompt, effective reviews of its social workers' performances.

- Ensure that its social workers initiate investigations of immediate and 10-day referrals within required time frames and complete the resulting case plan within 30 days.

- Institute a tracking system that will allow it to monitor the caseloads and workloads of its employees.

- Develop a caseload standard for each of its sections so that it can better determine when social workers are overburdened.

- Once the department has developed an effective caseload and workload tracking system and has established a caseload standard for its social workers, it should ensure that it has sufficient staff to stay within its caseload standard.

- Develop procedures for its employees to follow in providing child protective services.

To ensure that it provides appropriate and timely permanent placements to children within its purview, the juvenile court should:

- Implement an information system that would allow it to
  - ◊ monitor continuances and their causes,
  - ◊ monitor compliance with statutory hearing and process timelines, and
  - ◊ provide other pertinent management information such as court workload statistics.
- Consider implementing a mediation program.
- Consider assigning a presiding judge to at least a three-year term in accordance with local and state rules of court.

To prevent unnecessary continuances and shorten case processing times, the department should ensure that it submits its reports to the juvenile court at least 48 hours prior to the hearing date, that it submits transport orders promptly, and that it provides adequate notice of dependency hearings to required parties.

To strengthen its leadership role and improve its oversight of the State's child protective services, the DSS should:

- Continue with its schedule to review each county for compliance at least once every four years until it completes the implementation of its statewide automated child welfare services system, and then every three years thereafter.
- Review the counties' emergency response systems and administrative practices as part of its comprehensive monitoring approach.
- Continue to provide leadership to county child welfare agencies through progressive child welfare initiatives.

To ensure that the State is able to better identify trends and county and statewide systemic weaknesses in child welfare services, the Legislature should:

- Continue the pilot project initially started to establish a standardized child death reporting form.

- Require the appropriate state agency to establish a statewide child abuse and neglect fatality database using the processes developed by the pilot project.

Agency Comments

The department generally agrees with the findings in our report, noting that it has already begun to address many of our recommendations. The department believes that its new Child Welfare Services Case Management System will help it address many of the issues we raise in our report.

In addition, the juvenile court generally agrees with the recommendations contained in our report, noting that it also has begun implementing many of our recommendations. However, the juvenile court disagrees on the effect that judicial officer turnover has on dependency proceedings.

Finally, the DSS generally agrees with the recommendations made in our report, noting that it has already implemented many of them.

Introduction

Background

Kern County was organized in 1866 from portions of Los Angeles and Tulare counties. The county covers 8,172 square miles and is the third largest county in land area in the State. In 1996, the county was the nation's leading oil-producing county and the State's fourth most productive agricultural county. In 1995, Kern County had an estimated population of over 646,000 people, with approximately one third under the age of 18. The state average for this age group is 26 percent. Because Kern County supports a greater proportion of children than other counties in the State, the quality of services it provides to this at-risk population is even more important. Along with its law enforcement officers, the county's Department of Human Services and Juvenile Court are the primary agencies that protect children at risk of abuse or neglect.

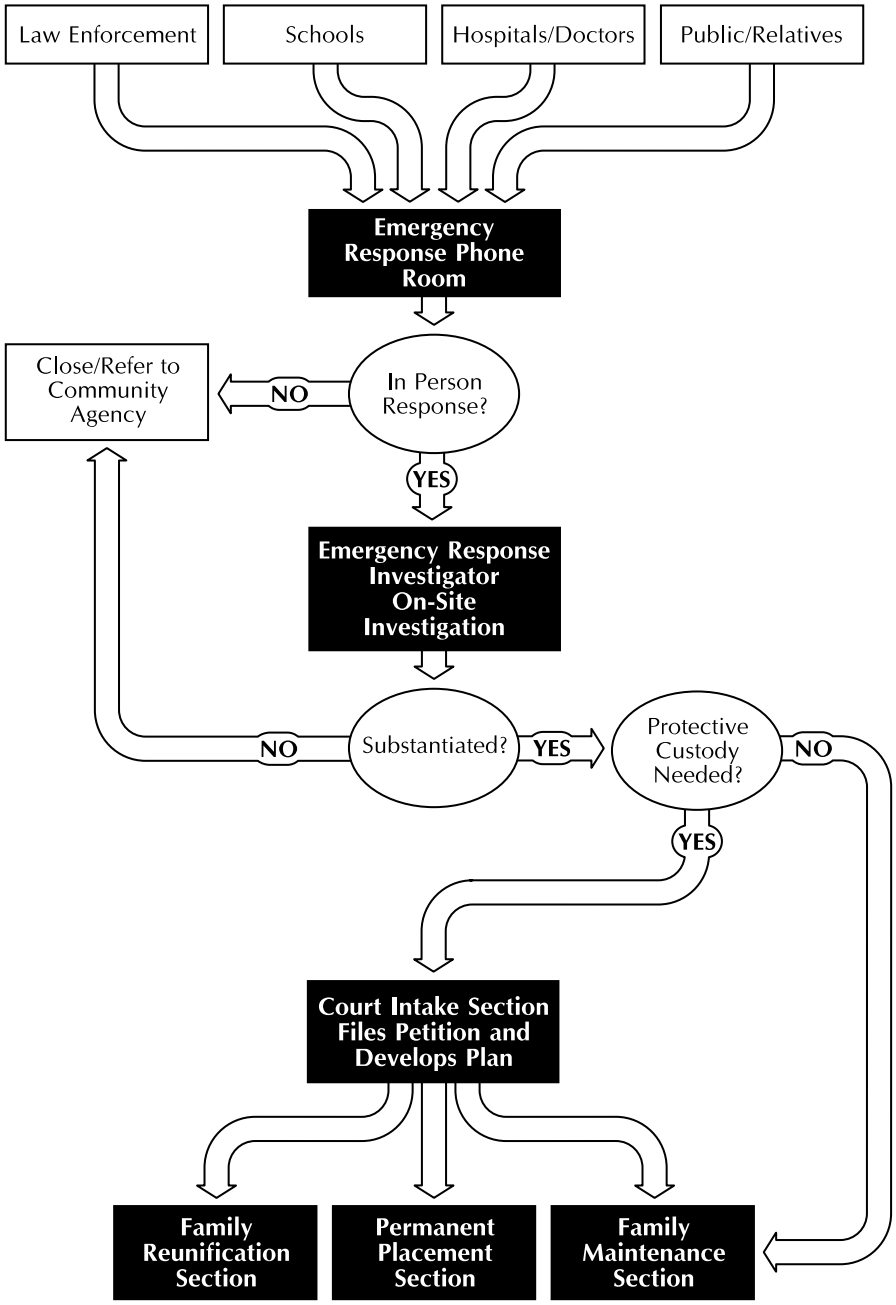
Overview of the Kern County Department of Human Services

Kern County established its Department of Human Services in 1921 to provide residents emergency aid. Today, its services can be categorized into three major areas: financial assistance, and adult and children's services. Children's services consist of 24-hour emergency crisis intervention for abused and neglected children. It determines how best to provide the safest environment for children, whether it be removal from the home and placement in foster care or working with the family to keep the children in the home. Children's services also include adoption and temporary shelter for children removed from their homes due to abuse or neglect.

The Family Preservation Bureau (department) of the Kern County Department of Human Services administers its children's services programs. The department consists of five sections: Emergency Response, Court Intake, Family Maintenance, Family Reunification, and Permanent Placement. The functions of these sections are summarized below and illustrated in Figure 1.

Figure 1

Child Protective Services Process



The Emergency Response Section consists of a phone room and several investigation units. The phone room fields allegations of child abuse and neglect, known as referrals. Staff in the phone room evaluate referrals and determine if an investigation is justified. If deemed necessary, a social worker from one of the investigation units visits the family to determine whether the allegations contained in the referral occurred. If a referral is substantiated, the investigator may for safety reasons remove the child from the home and place him or her into out-of-home care, such as foster care or a relative's home.

The Court Intake Section identifies the appropriate services for cases substantiated by the Emergency Response Section. For cases in which abuse or neglect has occurred and continued protective custody is necessary, the Court Intake Section prepares a petition that is filed by the county in Juvenile Court. Through a series of hearings in Juvenile Court, the court intake social worker addresses the family's problems by establishing a goal for the outcome of the case and developing a plan that includes services for family members to achieve the goal. These services may include counseling and courses in homemaking skills and parenting classes.

The Family Maintenance Section serves families when the child remains at home either through a voluntary agreement between the department and the family or through a court order. Services provided by this section may include counseling, respite care, and parenting classes. As the services are delivered, the family maintenance social worker evaluates the family's progress towards achieving the goals of the plan. If the goals are met, the case is closed. If the goals are not met, the child, for its health and safety, will eventually be removed from the home.

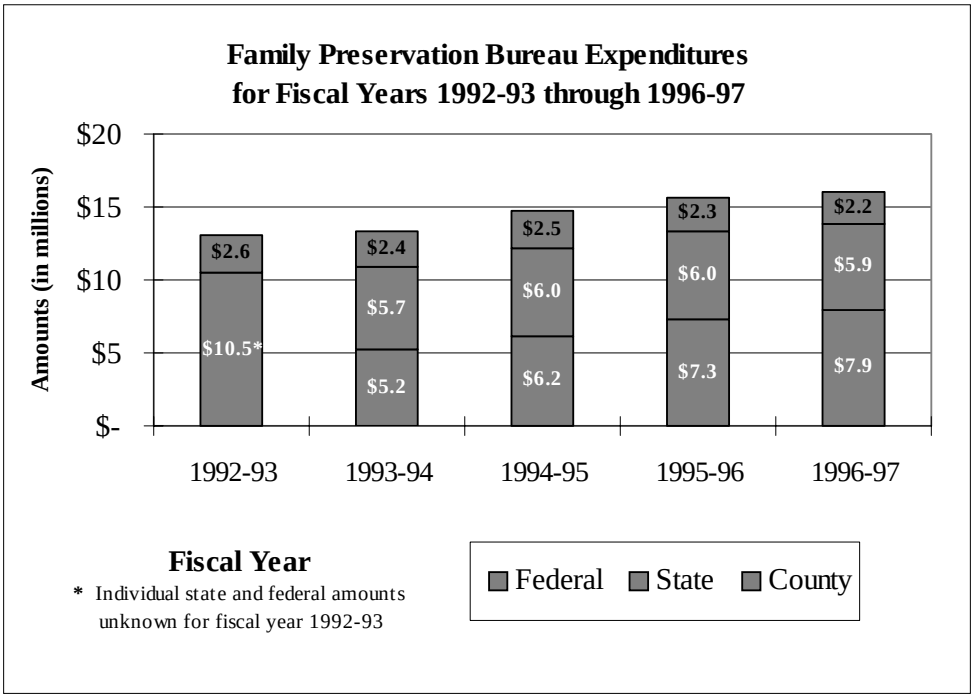
The Family Reunification Section serves families while the child is placed outside of the home. Typically, these services are intended to improve the home environment through family counseling, drug counseling, emergency shelter care, parent training, and courses in homemaking skills so that the child may be reunited with the family in a safe environment.

The Permanent Placement Section provides services to children who cannot safely live with their parents and are not likely to return to their own homes. These services include long-term foster care, legal guardianship, and adoption.

The department receives child protective services funding from federal, state, and county sources. State and federal funding allocations are based on the department's projected caseload compiled from actual caseload for the preceding three years.

As illustrated in Figure 2, the county share averages only about $2.4 million. Over the past five years, the department's total spending from all sources has ranged from $13 million to $16 million.

Figure 2

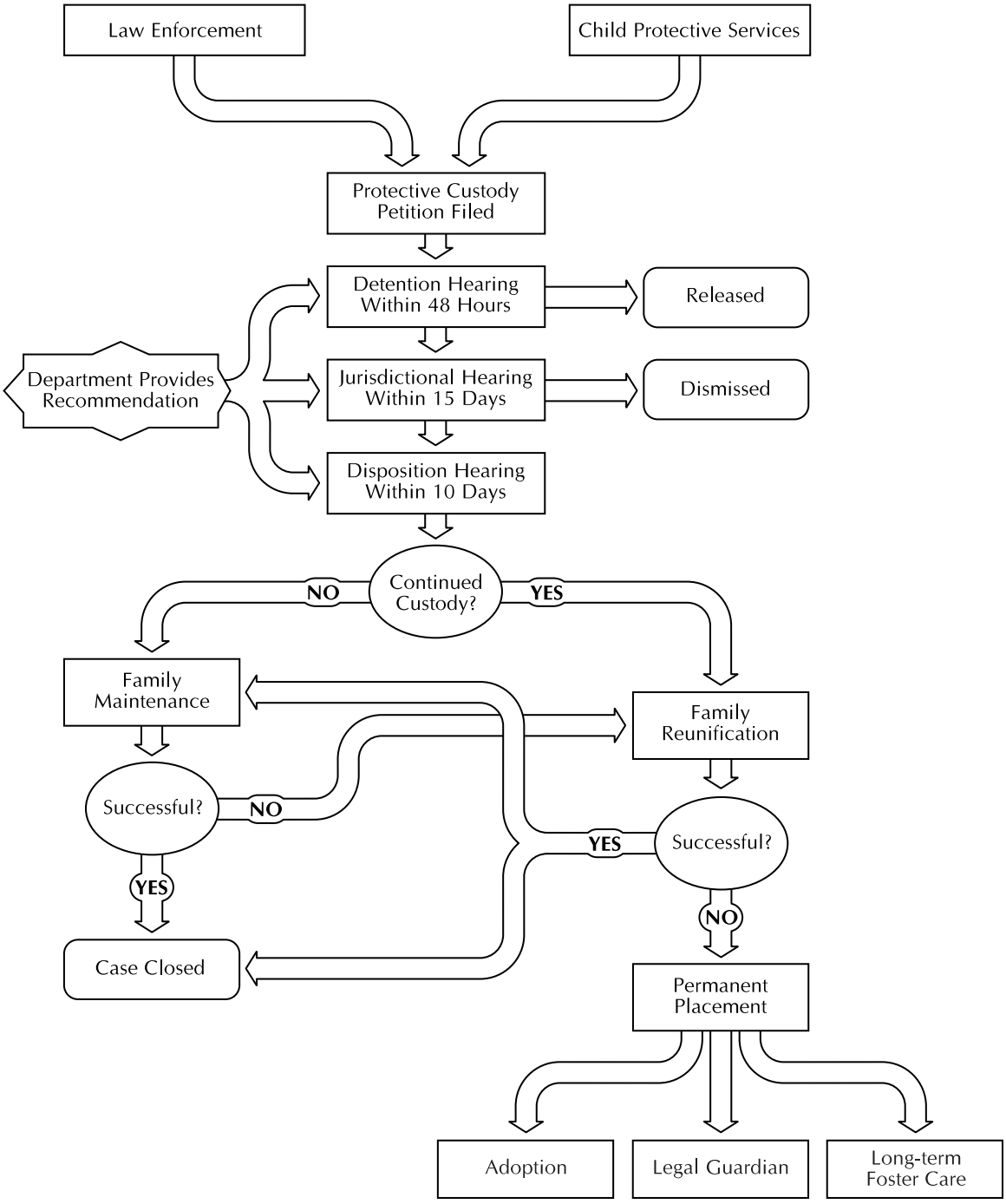


Overview of the Juvenile Court

The Kern County Juvenile Court (juvenile court) is part of the Superior Court of Kern County. The juvenile court has one judge and one referee who hear matters relating to minors. The juvenile court officers preside over dependency cases from the Court Intake Section of the department. Over a series of hearings, the juvenile court decides if evidence supports allegations of child abuse or neglect, and considers a resolution. Figure 3 illustrates this process.

Figure 3

Dependency Process



Role of the State Department of Social Services

The California Department of Social Services (DSS) oversees child protective services provided by counties throughout the State. DSS promulgates regulations for all counties to follow and monitors county compliance with those regulations. The Children's Services Branch of DSS's Children's and Family Services Division administers these and other child welfare programs.

Scope and Methodology

The Joint Legislative Audit Committee requested the Bureau of State Audits to perform an audit of the Kern County child protective services and related public agencies charged with the responsibility of protecting children. The purpose of this audit was to evaluate the policies and procedures the department established to protect children from abuse, neglect, and exploitation and to determine whether it and the related agencies adhered to them. The Joint Legislative Audit Committee also requested that we determine if the county had a role in the deaths of eight children from suspected child abuse between November 1995 and January 1997.

To gain an understanding of the overall child protection system in Kern County, we reviewed applicable laws, regulations, and other background information. Although many public and private agencies, including law enforcement, medical institutions, public schools, and community-based service organizations have roles in the child protective services network in Kern County, our initial review indicated that the primary responsibility for protecting children from abuse and neglect rests with the department and the juvenile court. As a result, our review in Kern County focused on these two agencies.

To identify the roles the department, the juvenile court, or other public agencies played in children's deaths due to abuse or neglect, we reviewed the case files for each such death since January 1995. As part of this review, we determined the extent of prior contact the agencies had with the families and whether the agency could have prevented these deaths. A summary of the death cases is presented in Appendix A.

To determine if the department was effectively protecting children from abuse and neglect, we interviewed appropriate department staff to obtain an understanding of policies and procedures and selected a sample of processed referrals to

ascertain if it had responded appropriately. Specifically, to evaluate the department's Emergency Response Section efforts, we selected a sample of referrals to determine if its intake process and investigations were consistent with applicable laws, regulations, policies, and procedures. To evaluate the department's other four sections, we selected a sample of substantiated referrals forwarded to the Court Intake Section for intervention. We determined if the Court Intake Section, and any other sections that serviced the case, consistently applied laws, regulations, policies, and procedures. To identify how the department monitored its social workers' caseloads, we interviewed section supervisors.

While reviewing the department's child protective services, we noted that an opportunity exists for the department to relocate one of its sections to the juvenile court building, a move which may improve the efficient handling of cases. We cover this issue in a separate letter addressed to the department.

To assess the juvenile court's operating effectiveness, we reviewed applicable laws and court rules and interviewed appropriate juvenile court staff as well as representatives from the County Counsel, the Public Defender, and the Indigent Defense Panel. In addition, we selected a sample of cases heard by the juvenile court and determined if its actions were consistent with the identified laws, rules, policies, and procedures.

To obtain an understanding of policies, procedures, and practices throughout the State, we surveyed child protective services offices in all 58 counties. A summary of the responses received from the counties is presented in Appendix B.

To determine the role the DSS has in the statewide system of child protective services, we reviewed applicable laws and regulations and interviewed appropriate DSS staff. We reviewed recent audits and evaluations on child welfare services in the State and examined DSS's responses to these reports. In addition, to evaluate its monitoring efforts, we reviewed DSS's timeliness and effectiveness in performing county compliance reviews. Finally, to identify its role in reviewing statewide child deaths, we interviewed staff from the DSS, as well as staff from the Department of Justice and the Department of Health Services who serve on the State Death Review Board.

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Chapter 1

Kern County Does Not Always Provide Prompt, Effective Child Protective Services

Chapter Summary

The Kern County child protective services system is made up of the Department of Human Services' Family Preservation Bureau (department), the Juvenile Court (juvenile court), and various community-based organizations. In our review of this system, we identified three points at which critical decisions are made relating to the health and safety of children at risk of abuse or neglect: in the department's Emergency Response phone room, in its Emergency Response investigations, and in the juvenile court.

We found that the department sometimes failed to obtain important information and did not always perform other required actions in responding to allegations of child abuse or neglect. For example, phone room staff did not always complete a checklist of critical attributes intended to guide the phone room social worker in deciding whether the department should investigate, nor did they obtain information from persons outside the immediate family who may have important information regarding the family's situation. Furthermore, we noted that the department does not always initiate or complete its investigations promptly, nor does it consistently obtain information from collateral contacts during these investigations. We also found that the department does not consistently complete a risk assessment to assist in measuring the risk of future abuse or neglect, hold conferences between supervisors and staff to discuss appropriate strategies when investigating a referral for a family it had previously investigated, or provide feedback to mandated reporters of the results of its investigations. Finally, we found that the department does not always visit the abused or neglected children or the parents as required.

Many of the weaknesses we noted were caused in part by a dramatic increase in referrals. However, the department's lack of effective management of its operations has also contributed to these weaknesses. For example, we noted that throughout the department's operations, supervisors did not consistently provide prompt and effective reviews of the work being performed. Further, the department has not established a

systematic method of monitoring its employees' workloads. Finally, the department has not developed procedures for its employees to follow in performing child protective services.

Emergency Response Phone Room Decisions Can Protect Children From Continued Abuse and Neglect

The Emergency Response phone room is the first key decision point in the department's process of identifying and responding to child abuse and neglect. This unit's decisions are critical to protecting the health and safety of children in Kern County. Although we found that the department's controls at this critical stage are generally effective in ensuring that referrals are properly received and assessed, we noted two areas in which it could improve its effectiveness.

The department's Emergency Response phone room social workers receive and screen referrals or allegations of child abuse or neglect. When someone makes an allegation, the social worker obtains as much information from the referring party as possible. Because the department does not have the resources to respond to every referral it receives, the social worker determines if the information merits an in-person response by a department investigator. If an in-person response is necessary, the social worker, with the supervisor's approval, then determines how quickly the department should respond. These are the first critical decisions the department must make regarding referrals.

To assist in these decisions, the department has adopted a protocol, developed by California State University, Fresno, that guides the social worker in evaluating the available information and deciding if an in-person response is necessary. This protocol suggests tools to aid an agency in evaluating the seriousness of allegations.

Phone room staff do not always complete sufficiency screens nor obtain necessary information from contacts.

The department does not always comply with laws, regulations, and its own policies in determining responses to referrals. We noted that phone room staff do not always complete sufficiency screens, nor do they always obtain necessary information from collateral contacts. The effective use of these tools is critical because the health and safety, or sometimes even the life, of a child may depend on the outcome of the decision. A proper decision in the phone room may assist social workers in saving a child from further abuse or neglect. Conversely, an incorrect decision may result in a child continuing to be abused or neglected and, in extreme cases, even killed.

A sufficiency screen is a checklist of key questions that aid a social worker in determining whether the department should respond in person to investigate allegations of child abuse or neglect. Of the 110 referrals we reviewed, a social worker should have completed all or a portion of a sufficiency screen on 28; however, we noted 8 instances (29 percent) when the social workers either had not completed or had only partially completed a sufficiency screen. Department of Social Services (DSS) regulations require the department to complete a sufficiency screen when it decides a referral is not appropriate for investigation.

By not consistently using sufficiency screens, phone room social workers may reach the wrong conclusion regarding the seriousness of a referral.

By not consistently using sufficiency screens, the phone room social workers may reach the wrong conclusion regarding the seriousness of a referral. Specifically, if a social worker determines a referral needs an in-person response when that referral does not merit such a response, valuable resources would be consumed that the department could have used on another referral. Conversely, the social worker could incorrectly decide that an in-person response is not necessary, thus leaving the child at risk of continued abuse or neglect. For example, in one of the child death cases we reviewed, we, as well as the department, found that the department did not properly complete a sufficiency screen.

Another tool phone room staff do not use consistently is collateral contacts. DSS regulations and the emergency response protocol adopted by the department require it to obtain information from collateral contacts. A collateral contact is an individual who has specific knowledge about an incident of alleged abuse, or relevant information, such as a neighbor, teacher, or child advocate. In 10 of the 110 referrals we reviewed, a potential collateral contact was included in information available to the phone room social worker. However, in 2 of these 10 referrals, the social worker did not attempt to contact the individual.

Even though the department's Emergency Response investigator later obtained information from collateral contacts in one of the two cases noted above and the other case was determined to be unfounded, and therefore information from collateral contacts was not necessary, the importance of phone room social workers obtaining information from collateral contacts is demonstrated in another death case we reviewed. In this case, the social worker failed to call a collateral contact who may have had information regarding the location of the child at risk because she thought confidentiality concerns prevented her from doing so. Rather, the social worker closed the referral, determining it was inappropriate for the department to investigate, and cross-reported it to local law enforcement.

Unfortunately, the child was killed before local law enforcement officials could locate him. Upon reviewing this case, the department concluded that the social worker should have made the phone call to the collateral contact.

Poor Supervisory Review Sometimes Allows Incorrect Phone Room Decisions To Go Undetected

Once the phone room social worker determines whether the department should respond to a referral, the phone room supervisor should review the decision. Although this review is a critical control in this stage of responding to allegations of child abuse and neglect, we found that supervisors do not always detect errors and omissions made by phone room staff. Specifically, as indicated in the sections above, in our review of 110 referrals, we noted 10 that the department failed to properly complete. However, in 9 of these referrals, a supervisor reviewed and approved the file even though it contained errors and omissions. In one other referral, we saw no evidence that a supervisory review was performed at all.

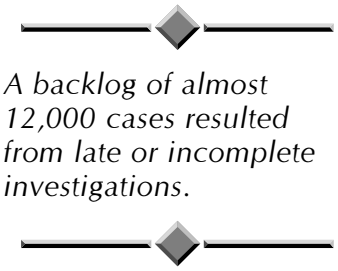
In nine referrals, a supervisor approved the file although it contained errors and omissions—one other had no supervisory review at all.

To maintain control at this critical point, the supervisor should review the social worker's performance in gathering and analyzing the information and determine the propriety of the social worker's decision before significant time has passed and the decision has been implemented. In addition, the supervisor should review the decision to ensure that the social worker has completed or obtained all information necessary to properly assess the situation. The supervisor must also ensure that the social worker's performance complies with DSS regulations and department policies. The regulations require the department to document the reason for the decisions made on each referral and to have the decision approved by a supervisor. Further, these regulations state that emergency response protocol for evaluating referrals is not complete without a supervisor's approval.

Because its supervisors' reviews were not always effective in detecting errors and omissions, the department cannot be assured that children are adequately protected from abuse and neglect. In one of the death cases previously discussed, a supervisor reviewed and approved the work performed. However, had the supervisor performed a more thorough review of the social worker's performance, the errors may have been detected and the death may have been prevented.

The effects of poor supervisory review are magnified because the department has provided few policies to its phone room staff to guide decisions and no written procedures on how to receive and evaluate referrals. Without clear policies and procedures, phone room staff may not clearly understand their roles and responsibilities.

The Department Does Not Always Act Promptly or Obtain Critical Information While Making Emergency Response Investigation Decisions



A backlog of almost 12,000 cases resulted from late or incomplete investigations.

Our review of the department's Emergency Response investigations, which are referrals from the Emergency Response phone room, disclosed that it is not always complying with laws, regulations, or department policy in five critical areas. For example, the department does not always promptly initiate or complete these investigations, resulting in a backlog of almost 12,000 cases. Additionally, the department does not always obtain information from collateral contacts, nor does it always complete a risk assessment to help determine the risk of future abuse or neglect. Moreover, the department does not always hold conferences between supervisors and staff to discuss appropriate strategies when investigating a referral for a family that was previously investigated by the department. Finally, the department does not always provide feedback to mandated reporters of the results of its investigation.

Emergency Response Investigations Are Critical To Determining the Safety of Children

An investigation is a direct result of the first key decision. At this stage, the phone room social worker has determined the child is in enough danger to require an in-person investigation. The referral is assigned to an investigator who reviews the information already obtained and then attempts to interview the parties included in the referral. Based on this information and initial interviews, the investigator determines whether allegations are substantiated, unsubstantiated, or unfounded.

A substantiated allegation indicates that the investigator obtained enough evidence to determine that the alleged abuse did occur. Normally, the agency bases its decision to substantiate on some credible evidence that constitutes child abuse or neglect. The investigator then performs a risk assessment to determine the potential for continued abuse or

neglect if the child is left in the home. Based on the risk assessment and the investigator's judgment, the investigator could provide services for 30 days or refer the family to services aimed at resolving the problems. In severe cases, the social worker may remove the child from the home and transfer the case to the Court Intake Section.

When an allegation is unsubstantiated, it means that the investigator was unable either to obtain evidence to support the allegations or to find that the alleged abuse did not occur. For example, a referral is unsubstantiated when a child has bruises, but neither the child nor the parents indicate that the bruises were the result of some form of abuse or neglect. In cases like this, the investigator assesses the risk of future abuse or neglect by completing a risk assessment. Based on this assessment, the investigator will either close the case, provide services to help the family, or refer the family to community-based organizations that can assist in resolving the problems.

An unfounded allegation indicates that the investigator determined the report to be false, inherently improbable, involved an accident, or did not constitute child abuse. If this is the result, the investigator should document the determination in the case record. The investigator either closes the case without further services or refers the family to a community-based service organization and then closes the case.

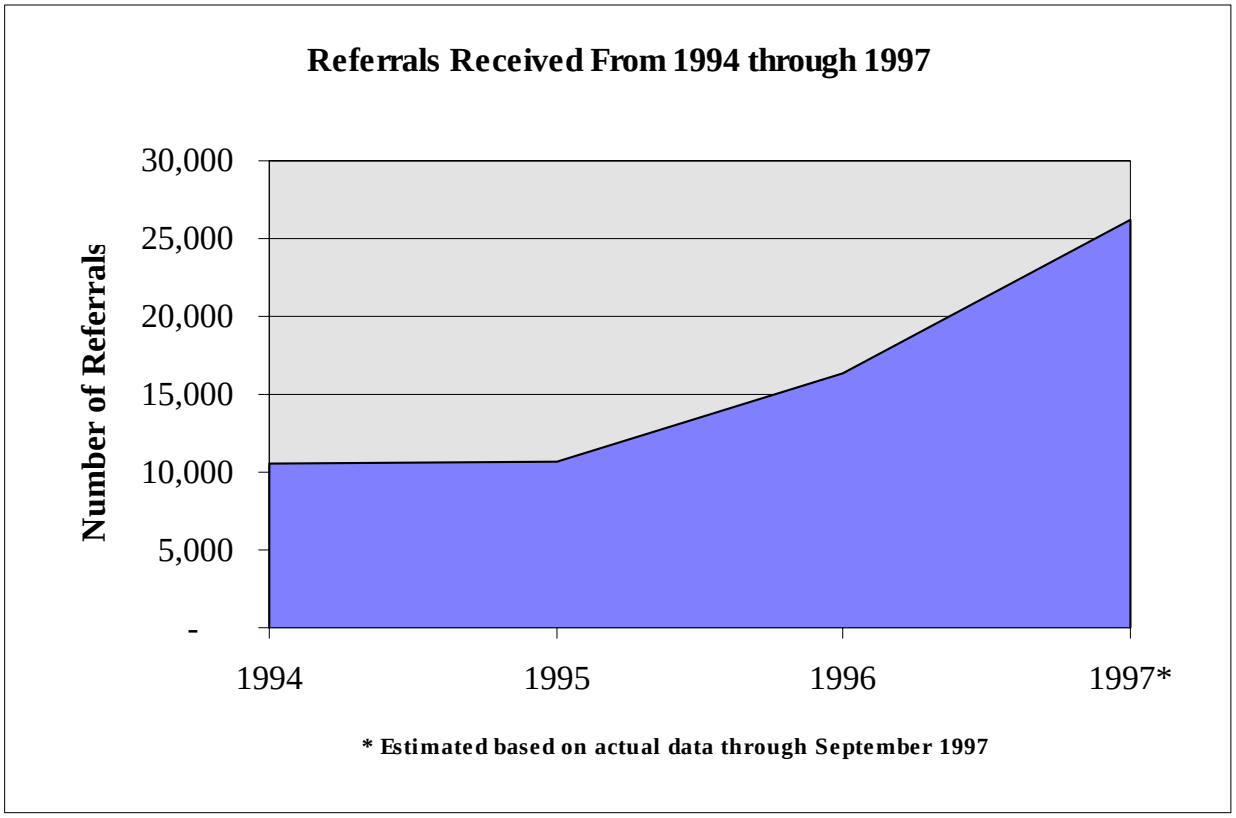
The Department Does Not Initiate or Complete Its Investigations Promptly

The number of instances the department failed to meet mandated response times appears to be increasing as its workload has increased.

The department is not promptly initiating or completing investigations of child abuse and neglect referrals so that critical decisions can be made appropriately. In our review of 110 referrals from 1995, 1996, and 1997, the department determined an investigation was needed for 82. In 6 of these 82 referrals, the department did not initiate its investigation within the time frames required by DSS regulations. These regulations require the department to investigate immediately those referrals that indicate imminent danger to a child is likely and to investigate within 10 days all others the phone room has forwarded for investigation. Moreover, the number of referrals for which the department exceeded the mandated response time appears to be increasing as its workload has increased.

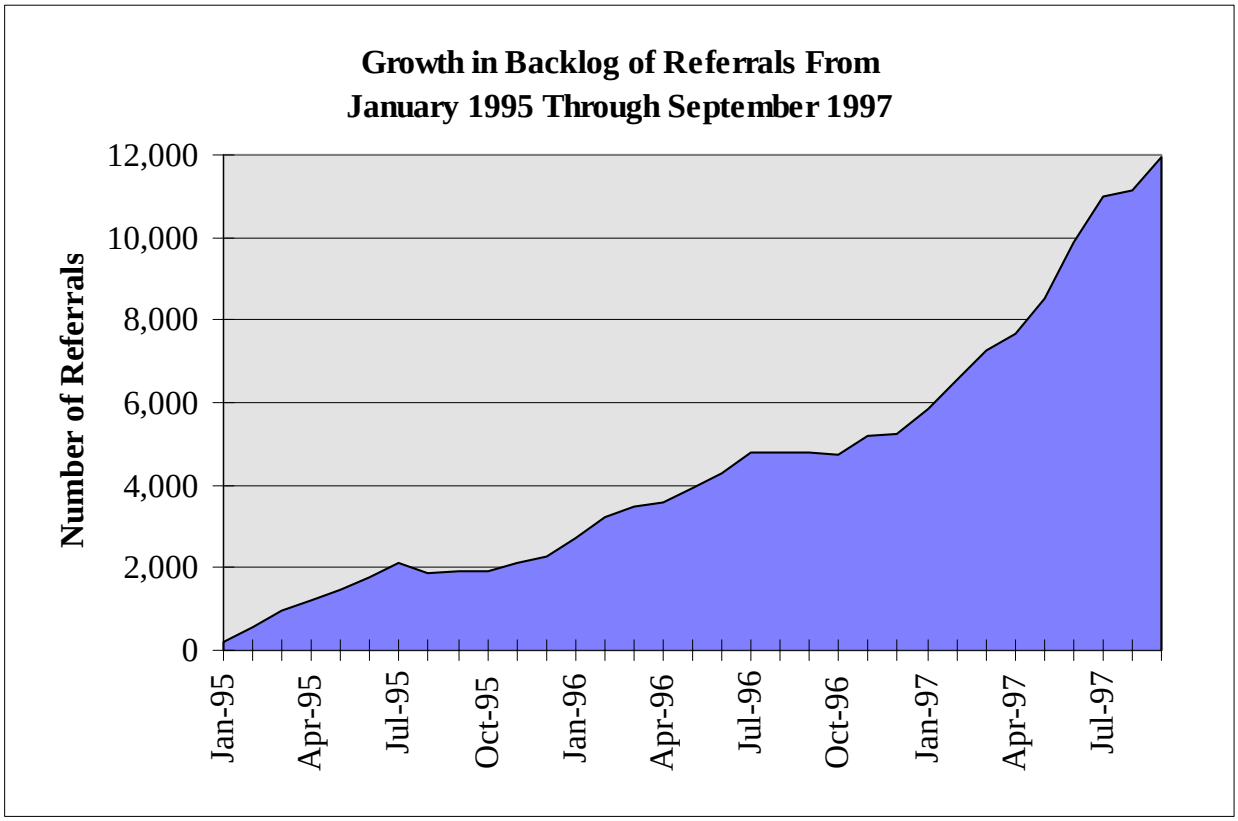
As Figure 4 illustrates, the number of child abuse and neglect referrals increased significantly in 1996 and continued to increase during 1997. The increase was attributable to a public awareness campaign the department conducted and a year-long series of print, television, and radio reports on child abuse conducted by the media in Kern County.

Figure 4



However, the department has not been able to keep up with the increased workload these efforts have produced. According to the department's activity reports, its Emergency Response Section has been able to increase the number of referrals it processes; however, it has not been able to process referrals at the same rate they are received, resulting in a backlog. As Figure 5 illustrates, as of September 1997, this backlog amounted to almost 12,000 cases.

Figure 5



The backlog includes cases not yet investigated or those for which the department has completed the investigation. Completed investigations remain part of the backlog because either the investigator has not written a report, the supervisor has not reviewed the report, or the department has not completed the process of closing the case on its information system. Because the department does not have a system to track or analyze its caseload, it does not know, and we were unable to determine, the types of referrals, or the aging of the referrals in its backlog. However, the department believes that most of these cases are lower-risk referrals that it has investigated but for which it has not completed an investigation report or supervisor review. The results of our tests of 110 cases support this belief.

In our review of the department, its inability to consistently respond promptly to the increased workload was evident. Specifically, of the 82 referrals we reviewed, 8 were received in 1995 and the department responded to all of them within 10 days, while 40 were received in 1996 with 3 late responses. However, of the remaining 34 referrals received

between January and July 1997, the department initiated its investigation late three times. To better determine the extent of its performance in responding promptly to referrals, we selected an additional 30 referrals the department received during May, June, and July 1997. It determined that an investigation was needed for 26 of these referrals; however, it responded late to 10. Therefore, out of 108 referrals the department should have investigated, it initiated its investigation late for 16.

Of the 108 referrals for which the department determined an in-person investigation was needed, 9 were identified as requiring an immediate response, and the remaining 99 were to be responded to within 10 days. The department responded promptly to all 9 immediate referrals. The total of 16 referrals noted above for which the department did not initiate a prompt investigation were all 10-day referrals, indicating lower risk. The average response time for the department to respond to the 10-day referrals was 8 days, ranging from 0 to 51 days. Only 2 of the 16 referrals the department initiated late were over 30 days late. Therefore, although it may not always initiate its investigation within 10 days, late investigation of referrals does not appear to be the cause of the backlog of almost 12,000 cases.

The department did not complete an investigation within 30 days in 74 percent of the cases we reviewed.

In addition to the department not promptly responding to the referrals it investigates, we also noted that it does not always complete its investigations within 30 days of the initial investigation, of the initial removal of the child, or by the date of the dispositional hearing, as required by DSS regulations. In 80 of the 108 referrals (74 percent) we reviewed, the department did not complete a case plan and a supervisor did not review the case file, both required by regulations, within 30 days of the date of the initial investigation. Without a completed case plan, the department is not able to identify the needs of the family and forward the case to the department's other sections that facilitate these services.

Furthermore, in one instance, the investigator did not complete the investigation for almost 9 months. Moreover, for 12 of the 80 referrals, the department did not complete a case file until we requested the file as part of our sample. As a result, there is no way to know when these files would have been completed if we had not requested them as sample items. Finally, 14 of the 80 referrals had not been closed by a supervisor, even though 8 of the 14 had been received in 1996, and 1 had been received in 1995.

The department indicated that it has to prioritize its social workers' caseloads because of the high volume of referrals it receives. As a result, it may not always initiate an investigation

within 10 days or complete them within 30 days of the initial investigation. The department prioritizes its response to referrals based on assessed risk. For example, an immediate referral has a high risk associated with it, and therefore the department investigates it before other lower-risk referrals. Similarly, a physical or sexual abuse referral has a higher risk associated with it than does a general neglect referral.

When the department does not respond promptly, a child may endure further abuse or neglect.

When the department does not respond promptly, a child may endure further abuse or neglect. A late response could also adversely affect the investigation, because the department may not then be able to properly assess the referral. For example, in one referral we reviewed, the department did not respond for 51 days, 41 days past the 10-day deadline. The referral included an allegation of marks on the child, which indicates moderate risk; however, by the time the department responded, the marks were no longer visible. In this case, the investigator determined the allegation was unfounded because of a lack of physical evidence or corroborating evidence from the victim. However, because the response was so late, a crucial piece of evidence, the marks, may have healed by the time the department responded. If the department had responded within the 10-day timeline, it would have been able to determine if the child did have marks.

The Department Fails To Use All Available Tools To Determine Risk

The DSS regulations require the county to make necessary collateral contacts with persons having knowledge of the condition of the child. Of the 110 referrals we reviewed, 38 listed collateral contacts that the investigator should have contacted; however, the department did not obtain information from collateral contacts in 3 of these 38 referrals. Collateral contacts can provide the investigator with additional information about the incident of alleged abuse. Collateral contacts can either confirm or discount the investigator's own perception of the family and its situation, and the information they provide could assist the investigator in deciding whether to intervene on behalf of the child. Consequently, the social worker may inappropriately remove the child from the home or leave the child in the home to suffer continued abuse or neglect.

Risk assessments should have been completed for 56 cases we reviewed; however, 7 were not completed.

The department requires investigators to complete a risk assessment, a tool to help determine the risk of future abuse or neglect, whenever they determine a referral is substantiated or unsubstantiated. In our review of 110 referrals, the department should have completed risk assessments for 56; however, we noted that the department had not completed 7. The department uses a risk assessment tool developed by California State University, Fresno, which is designed to assist social workers in determining the most critical risk factors and the services needed to alleviate the risk to the child or family. If this tool is not used adequately, the department's decisions may not be sound and may not adequately protect the child.

Until January 1997, the department did not have a written policy requiring investigators to complete risk assessments. Five of the seven cases lacking a completed risk assessment were processed prior to January 1997. According to the assistant director, the department's policy regarding the use of risk assessments was informal until January 1997 when the department implemented a written policy requiring risk assessments for certain referrals. Currently, the department is drafting an additional policy and related protocol to instruct its investigators when to complete a risk assessment. Another reason the department did not always complete risk assessments is because supervisors failed to thoroughly review case files. In three of the seven cases noted above, a supervisor had reviewed and approved the files despite the lack of a completed risk assessment; and in the other four cases, a supervisor had not yet reviewed the files, even though the referrals were at least three months old.

The Department's Communication of Information Is Inadequate

Passing on information from one step of the process to the next is vital to the success of protecting at-risk children. An example of the department's inadequate communication system is its failure to conduct strategy meetings between investigators and supervisors for families with two or more past referrals.

The department has a written policy that requires its investigators to meet with their supervisor to plan strategies to provide services for such families. In our review of 110 referrals, we identified 58 that had at least two prior referrals. However, we saw only one instance in which the department had implemented this policy, even though 24 of the 58 happened after the effective date of its policy. The purpose of the meeting is to determine what services the department should provide to the family to help solve its problems. While

the department's policy does not suggest that social workers with prior knowledge of the family attend this meeting, we believe it would be beneficial for the new social worker. This is particularly important because, even though the department received prior referrals, these may have been investigated by different social workers. With more complete knowledge of the family's circumstances, the social worker currently assigned to the investigation can develop a case plan that more accurately addresses the family's problems. Furthermore, these meetings may help the department provide better services to families that have a history of abuse or neglect and perhaps even prevent future referrals from occurring. Finally, the department could increase its effectiveness, and possibly reduce future workloads, by following this policy.

The department failed to report the results of its investigations to mandated reporters in 8 of 49 instances.

Another example of the department's inadequate communication is its failure to consistently report the results of its investigations to mandated reporters. Of the 110 referrals we reviewed, the department received 49 from mandated reporters. In 8 of these 49 referrals, the department failed to provide feedback. The State Penal Code mandates certain groups of people, including doctors, school nurses, law enforcement officers, and counselors, to report suspected child abuse. The State Penal Code also requires the department to provide feedback to the mandated reporter after investigation. The department's written protocol details when and how a social worker should provide feedback to a mandated reporter; however, the social workers do not always follow the protocol.

Mandated reporters usually are persons who have ongoing contact with children, and they are the first line of defense against child abuse and neglect. Therefore, the exchange of information between the department and the mandated reporters is critical to sustaining this method of identifying and preventing future abuse and neglect. By providing feedback to mandated reporters, particularly those referrals with positive outcomes, the department may also encourage these individuals to report future instances where they may suspect abuse or neglect of a child.

Excessive Caseloads Contribute to the Department's Inability To Consistently Investigate Referrals Promptly

Our review of the average monthly caseload for social workers in various sections disclosed that the department's Emergency Response investigators, who are social workers, carry an excessive number of cases. As a result, the investigators are not always initiating or completing investigations promptly, and

they do not always complete the investigation properly. The caseloads of the department's Emergency Response investigators far exceed standards established by the Child Welfare League of America (CWLA) and the DSS. While excessive caseloads are a result of the increased number of referrals the department receives, its lack of guidance to its employees in distributing and monitoring caseloads has magnified the effects of this increase. The department is currently implementing a computer system that may help track caseloads. However, without proper controls and guidance over the new system, it too will fail to provide the caseload tracking information that would allow the department to effectively manage referrals of child abuse or neglect.

Caseloads for the Department's Emergency Response Workers Exceed Standards

The CWLA is a nonprofit association that assists children and families. It has recommended workload standards for child protective services social workers in its publication Standards for Service for Abused or Neglected Children and Their Families. The DSS has also developed workload standards for county child protective services agencies which, along with caseload information from the counties, it uses to determine funding for these agencies in the 58 counties.

Using the monthly caseload reports the department prepares from data submitted by social workers, we calculated the average caseload per worker for the fiscal year ending June 30, 1997, for all sections except Emergency Response. The department's Emergency Response Section does not track the caseloads of its investigators; therefore, to compare the caseload for social workers in the Emergency Response Section to the standards established by CWLA and DSS, we determined the average number of assignments in a month per social worker using the logs the department keeps to record assignments. In Table 1, the average monthly caseload per social worker in each section is compared to the corresponding DSS and CWLA standard.

As the table illustrates, the department is below the CWLA and DSS prescribed standards for the Family Maintenance and Family Reunification sections, and only slightly above the DSS standard for the Permanent Placement Section. The Permanent Placement Section does not track caseload by the number of families; therefore, it is difficult to compare department data to the CWLA standard. However, by

Table 1

Comparison of Kern County Caseloads With DSS and CWLA Standards

Kern County			
Kern CPS Section	**Average Monthly Caseload**	**DSS Standard**	**CWLA Standard**
Emergency Response	25.7 investigations	15.8 children	12 investigations[a]
Court Intake	30.5 children	None[b]	None[b]
Family Maintenance	33.4 children /15.5 families	35 children	17 families
Family Reunification	24.1 children / 9.4 families	27 children	17 families
Permanent Placement	56.4 children	54 children	17 families

[a]The CWLA revised its Emergency Response caseload standard to 14 investigations in a review of Riverside County's child protective services system because the investigators did not perform the court work associated with the investigations. Kern County's investigators also do not perform the court work for their cases; therefore, a standard of 14 is more appropriate.

[b]Neither the DSS nor the CWLA have promulgated standards for the court intake unit.

using the children-per-family ratios from the Family Maintenance and Family Reunification sections, the CWLA standard for the Permanent Placement Section would be between 34 and 51 children. However, since the amount of work required at the permanent placement stage of dependency is less than at the family maintenance and family reunification stages, the caseload for the social workers in the Permanent Placement Section does not appear to be excessively, if at all, over the CWLA standard. Neither DSS nor CWLA has a standard to compare to the department's Court Intake Section.

Emergency Response's average monthly caseload is well above the standards prescribed by the DSS and the CWLA.

In contrast to the other sections, Emergency Response's average monthly caseload of 25.7 investigations is, at 62 percent, well above the standard of 15.8 prescribed by DSS and more than double the standard of 12 set by the CWLA. Additionally, the DSS standard is measured by the number of children a social worker serves. The only data we were able to obtain from the department was measured by the number of investigations a social worker has. Because an investigation may include more than one child, the department may exceed this standard by even a greater margin. Furthermore, the number of new assignments Emergency Response investigators receive each month has been markedly increasing over the past year, from 18.9 per social worker in July 1996 to 28.5 in June 1997 and as many as 33 new investigations per social worker in March 1997. Moreover, the number of new assignments vary

among social workers, and in some cases Emergency Response investigators are assigned more than 40 new investigations per month, which is more than three times the CWLA standard.

The department's supervisors appear to carry workloads that are near, or just slightly above, standards promulgated by DSS and considerably higher than the CWLA standard. As illustrated in Table 2, the department's supervisor-to-social worker ratio for each of its sections is near the DSS standard of seven for each section and up to 80 percent above the CWLA standard of five.

Table 2

Comparison of Kern County Supervisor-to-Social Worker Ratio With DSS and CWLA Standards

Kern CPS Section	Kern County Average Supervisor/ Social Worker Ratio	DSS Standard	CWLA Standard
Emergency Response	1 : 7.9	1 : 7	1 : 5
Court Intake	1 : 8.0	1 : 7	1 : 5
Family Maintenance	1 : 5.5	1 : 7	1 : 5
Family Reunification	1 : 8.8	1 : 7	1 : 5
Permanent Placement	1 : 6.7	1 : 7	1 : 5

The ratios in Table 2 are an average of seven months, including May through November 1997. The range for the Emergency Response Section during this time was one supervisor to 7.3 social workers in June, to one to 10.4 in September. In November, the Emergency Response ratio decreased to one to 8.2 when the department added a new supervisor. Additionally, the department has advised us that it has received approval to hire three more supervisors, which should lower its supervisor ratios even further.

Because of increasing investigations assigned to its Emergency Response workers each month, the risk of children being exposed to continued abuse and neglect also increases.

Because the number of investigations the department is assigning to its Emergency Response workers each month is increasing, the risk of children being exposed to continued abuse and neglect also increases. The CWLA made a similar conclusion in its March 1996 report on Riverside County's Child Protective Services agency. In its report, the CWLA stated that "High caseload size makes it very difficult for ER social workers to do their jobs well. When the demand outstrips the capacity of a child protection system to respond (ER Section), tough decisions must be made. Over-stressing the staff lessens their ability to make sound decisions." Finally, while the

CWLA recommends that all child protective service organizations develop their own caseload standards to monitor workload properly, the department has not established its own caseload standards.

The Department's Current System Does Not Promote Effective Caseload Monitoring

Caseload monitoring is vital to ensuring that effective child protective services are being delivered. However, the department has not established a systematic method or provided policies or procedures to guide its supervisors in monitoring the caseloads of the social workers under their supervision. As a result, with the exception of Emergency Response, each section has developed a manual system to monitor the caseloads of its employees. However, these manual systems of tracking caseloads are not effective. Most supervisors monitor caseloads by requiring their workers to submit caseload information at the end of each month.

One shortcoming of these methods of caseload monitoring is that they provide supervisors with information that is accurate for only a particular point in time. Therefore, the supervisors do not have current caseload information at any point other than at the end of the month. Additionally, these monitoring systems rely completely upon the workers to report their current caseloads, but the department has not established any controls to ensure that the information is reliable or accurate.

The department has not implemented adequate controls over the information contained in its referral tracking system and it is no longer reliable.

An important component of a caseload tracking system is an information system that can provide supervisors and management with reliable caseload information. Until recently, the department used its Family Preservation Bureau (FPB) information system to track referrals as well as to open and close cases. When the department inputs a referral, the FPB system assigns a number to it. The department also assigns each social worker a caseload number on the FPB system. The system links the referral number to the worker caseload number, which allows the department to obtain information in desired formats, such as caseload per worker. However, the department has not implemented adequate controls over the information contained in the FPB system and it is no longer reliable.

For example, since October 1996, the department has allowed its social workers to close cases on the FPB system prior to having them reviewed by supervisors. These cases no longer

show up as active, even though a supervisor has not yet reviewed them. As a result, supervisors cannot use the FPB system to determine what cases are ready for their review, nor can they assure that all cases are reviewed.

Supervisors Do Not Manage Caseload Levels or Effectively Monitor Response Time

Since social workers are assigned new cases throughout the month, it is important that supervisors are aware of current caseload information so that they can evenly distribute the workload. Some sections within the department make assignments on a rotational basis. That is, one case is assigned to each available worker until each has received a case, and then the first worker is assigned another case. Some sections use variations of this assignment method. For example, cases entering these sections are assigned on a rotational basis to the workers who are responsible for cases in that specific geographic region within Kern County. However, the rotational case assignment method does not take current caseload into account and, therefore, can result in inequitable caseloads among workers. If supervisors tried to consider caseload when making assignments in an attempt to keep caseloads equitable, they may not be effective because the caseload information provided by the current manual monitoring systems is not always current or reliable and, therefore, supervisors may be unaware of inequitable caseload distributions. As a result, the supervisor would not be able to correct the inequities and would continue to assign cases to all workers regardless of the current workload.

The most serious problem in tracking caseloads resides in its Emergency Response Section, where two of the three key decision points exist.

The department's most serious problem in tracking caseloads rests in its Emergency Response Section, where two of the three key decision points in the county's system of child protective services exist. If the phone room supervisor agrees that a referral should be investigated, she assigns the referral to an Emergency Response investigator. Such assignments are usually made based on the geographic region in which the referred child resides. Using the log book of case assignments, the phone room supervisor can track how many assignments have been made to each investigator during the current month.

Although the phone room supervisor keeps track of the number of cases assigned to each investigator, neither she nor the investigator's supervisor track the progress of the case after it is assigned. The department states that the phone room supervisor tracks investigator's caseloads using its FPB system. However, during our review, we determined the information

from this system may not be accurate or reliable and, therefore, would not be effective for monitoring caseloads. For example, in July 1997, the department stated that the average caseload for the preceding year for its Emergency Response investigators was 63. However, an FPB report that the department provided us covering the same period indicated an average caseload of 90, with some investigators routinely carrying over 300 cases each and as many as nearly 600. Therefore, because the data are not accurate, if the phone room supervisor uses this FPB data when assigning cases, she may not assign them equitably. Moreover, the phone room supervisor could be misled regarding overburdened or underworked investigators.

The Emergency Response supervisors also do not proactively monitor how promptly investigators complete their work. For example, supervisors do not track the amount of time that has elapsed since the department received the referral. Often, an Emergency Response investigator will conduct an investigation of a referral and decide that no action needs to be taken by the department. Rather than completing an investigative report and submitting it to the supervisor, the investigator will go on to investigate a different referral. Because the Emergency Response supervisors are not always aware of the disposition of these cases until the investigators write them up and submit them, a child potentially could remain in a high-risk situation. In addition, because they do not track the progress of referrals assigned to investigators, supervisors cannot identify instances in which an investigator has not promptly begun an investigation. For example, during our review, we noted an investigator who had 30 referrals that he had not yet investigated. When he informed his supervisor of the 30 cases, the supervisor reassigned them to other workers. Twelve of these referrals were more than one month old, and nine others were more than two months old at the time they were reassigned to other Emergency Response investigators. In addition, 10 of the 30 referrals were for physical abuse.

Supervisors do not track the progress of referrals assigned to investigators and cannot identify when an investigation has not begun promptly.

A New System May Adequately Track Workload and Caseload

Child Welfare Services/Case Management System (CWS/CMS) is a statewide information system currently being implemented in all 58 California counties. This system was designed to provide for the information needs of both the county child protective services agencies and the DSS. When fully implemented, the CWS/CMS systems in all counties will be linked to each other and the DSS. The department recently began using this system for its everyday operations.

According to the department, the CWS/CMS will provide it with a workload tracking system, as it requires the workers to complete their work and enter certain data directly onto the system. Furthermore, the system will allow the supervisors access to all data entered into the system by their workers. Therefore, the supervisors will have the ability to examine each worker's caseload, determine cases that workers have closed and that need supervisory review, review the individual cases on the system, determine the status of all assignments made to workers, as well as to perform various other tracking duties. Additionally, the system has the capability to identify cases that are beyond statutory timelines, need court reports prepared, require visits to minors, and provide other important information. Furthermore, the CWS/CMS has controls over who can close cases, who can input data, and who has access to the various data screens.

If the CWS/CMS functions the way it is intended to, it will provide the department with an adequate workload monitoring system. However, it appears to us that the FPB system could have provided an adequate workload monitoring system if the department had instituted and maintained proper control to ensure the reliability of the data and implemented policies and procedures to instruct each section about how to monitor its workload. Therefore, the department must properly use the capabilities of the CWS/CMS and institute proper controls to maintain the reliability of the data. Also, the department must implement policies and procedures to address workload monitoring at the section level. If the management does not ensure that these steps are taken, the CWS/CMS could become as unreliable as the FPB system.

If the department does not ensure that proper controls are in place, the CWS/CMS could become as unreliable as the prior system.

Social Workers Are Not Always Properly Implementing Case Plans in Other Sections

Many of the problems that exist in the department's Emergency Response Section also affect the department's other sections. Although cases that reach the Court Intake, Family Maintenance, Family Reunification, or Permanent Placement sections have already received a great deal of attention by the department, and two of the three key decisions in the child protective services process have already been made, the activities of these sections are still vital to identifying and addressing the problems that led to the abuse or neglect.

However, these sections do not always provide services properly. Specifically, we noted several instances in which social workers did not comply with regulations while their cases

were in the Court Intake, Family Maintenance, and Family Reunification sections. For example, although DSS regulations require social workers to visit minors three times within the first 30 days and require social workers to make contacts with minors and parents monthly thereafter, we found 6 instances out of the 12 referrals we reviewed from the Family Reunification Section and 3 instances out of the 5 referrals we reviewed in the Family Maintenance Section in which the social worker did not make all required visits. The social worker assesses the child's needs and desires on these visits and ensures that the present placement is appropriate and safe. When the department does not conduct these visits, the child's well-being could be at risk.

We found the department did not ensure that:

- *social workers make all the required visits,*
- *drug tests are administered,*
- *signatures of the parent/caretaker are obtained on case plans, and*
- *supervisors in the Court Intake Section promptly review fees.*

We also noted that the department did not administer drug tests in one of the five cases we reviewed from the Family Maintenance Section. We also noted four instances out of the 13 referrals we reviewed from the Court Intake Section in which the department did not obtain parent/caretaker signatures on case plans. By not obtaining signatures, the department cannot assure that parents are aware of expectations outlined in the case plan. Finally, we noted two instances out of the 30 referrals we reviewed from the Court Intake Section in which a supervisor did not promptly review the file. In one of these cases the supervisor did not review the file until five months after it was closed. As a result, if the worker did not adequately perform his or her duties in this particular case, it would be far too late to remedy the situation when the supervisor reviewed the case file.

The Court Intake, Family Maintenance, Family Reunification, and Permanent Placement sections do not have a workload tracking system that would help to assure required activities are completed promptly and appropriately. An effective workload tracking system that identifies what actions are required for each case, establishes when the actions should be completed, and monitors their prompt completion would allow supervisors within these sections to proactively ensure that cases under their supervision comply with all required practices, such as monthly visits or drug tests. Currently, supervisors do not always review cases while social workers are actively providing services. As a result, the department does not know if its actions taken on a case are out of compliance with required practices until after a case is closed, which is too late to correct any deficiency.

Conclusion

Over the past three years, the department experienced a significant increase in the number of referrals of child abuse and neglect it received. However, it has not kept up with this increase, resulting in a backlog of cases. Furthermore, the department does not always obtain important information or perform critical tasks in evaluating, investigating, and servicing the cases it processes. For example, the phone room social workers do not always complete sufficiency screens designed to assist them in making the critical decision to respond to a referral of abuse or neglect. Also, the Emergency Response investigators do not always initiate or complete their investigations promptly, and they do not always complete a risk assessment tool designed to assist the investigator in determining if a child is at risk of future abuse or neglect. Finally, social workers in the sections that develop and implement case plans do not always visit the children and parents as required to ensure that the children are safe and the parents are complying with the case plan.

While the increased workload it experienced in the last three years undoubtedly has affected the department's ability to properly process referrals, its lack of effective management oversight for its operations has also contributed to these weaknesses. For example, throughout the department's operations we noted that supervisors did not always provide prompt or effective reviews of the work being performed. Further, the department has not established a systematic method of monitoring its employees' workloads. Finally, the department has not developed procedures for its employees to follow in performing child protective services. As a result, the department cannot assure it adequately protects the children of Kern County from continued abuse and neglect.

Recommendations

To ensure that it provides prompt, effective child protective services, the department should:

- Ensure that its supervisors are providing prompt, effective reviews of its social workers' performances.

- Ensure that its social workers initiate investigations of immediate and 10-day referrals within required time frames and complete the resulting case plan within 30 days.

- Institute a caseload and workload tracking system that will allow it to monitor the caseloads and workloads of its employees.

- Develop a caseload standard for each of its sections so that it can better determine when its social workers are overburdened.

- Develop procedures for its employees to follow in providing child protective services.

Once the department has developed an effective caseload and workload tracking system and has established a caseload standard for its social workers, it should ensure that it has sufficient staff to stay within its caseload standard.

Chapter 2

The Juvenile Court Can Improve Its Process of Adjudicating Child Abuse and Neglect Cases

Chapter Summary

The Kern County Juvenile Court (juvenile court) makes critical decisions regarding the protection of minors from abuse and neglect. In our review of the juvenile court, we found that it agreed with the Kern County Department of Human Services' Family Preservation Bureau (department) on the safest and most appropriate placement for minors in over 99 percent of dependency hearings. However, the juvenile court often continues hearings, which lengthens the time that minors must remain in a contested dependency proceeding. Lengthy proceedings may add to the degree of stress placed on minors by the dependency process. Although some of these continuances are not the juvenile court's fault, they could be avoided by the department or the California Department of Corrections acting promptly. Additionally, although the juvenile court in Kern County takes less time than juvenile courts in other California counties to process similar cases, it exceeds state requirements for completing hearings. Therefore, the juvenile court should consider ways to shorten case-processing times, such as implementing a mediation program to reduce court workload and an information system to track continuances, case-processing times, and other pertinent data.

If the Department Removes a Minor, It Must Seek the Approval of the Juvenile Court

In Chapter 1, we discuss the first two key decision points we noted in Kern County's child protective services system. The third key decision point we identified rests with the juvenile court. When an emergency response investigator determines that a minor should be removed from his or her caretakers, the department must file a petition with the juvenile court within 48 hours to initiate a legal process intended to protect minors. The juvenile court determines whether the minor can safely remain at home or should become a dependent of the court and it decides what services the minor and his or her family should

receive. Figure 3 in the Introduction illustrates the juvenile court process. To make these determinations, the juvenile court must proceed through a series of hearings, which are described in Table 3.

Table 3

Description of Juvenile Court Dependency Hearings

Type of Hearing	Timeline	Purpose
Detention	Within one court day of petition filing	The juvenile court determines whether the minor should continue to be detained. The department must prove there is a substantial risk the minor will be abused or neglected if returned home.
Jurisdiction	Within 15 court days of detention hearing	The juvenile court determines whether the allegations listed in the department's petition are true. The department must prove that the allegations in the petition have more than a 51 percent probability of being true.
Disposition	Within 10 court days of the jurisdiction hearing	The juvenile court determines, among other things, whether the minor can safely return home or should continue to be detained from his or her parents' custody. The department must prove by "clear and convincing" evidence that returning the minor to his or her parents would create a substantial risk of danger.
Review	At least every 6 months, for up to 18 months, after the disposition hearing	The juvenile court reviews the case to monitor the progress of the minor and his or her family in achieving the goals of the case plan.
Permanent Plan	Within 120 days of terminating family reunification services, which must be terminated no later than 18 months after the child is detained	The juvenile court chooses adoption, legal guardianship, or long-term foster care as a permanent plan for the minor. The department is required to submit a report containing recommendations.

For each hearing, the department submits recommendations to the juvenile court supported by evidence; however, the juvenile court may release the minor to the family at any step in the hearing process if it decides the department is unable to prove a

substantial risk to the minor exists. Such a decision is called an "adverse decision" and could result in the minor's return to a family situation the department evaluated as dangerous.

In Kern County, the juvenile court rarely issues adverse decisions. Specifically, it issued only one adverse decision out of our audit sample of 178 hearings. That is, in over 99 percent of hearings, the juvenile court and the department agreed on the safest and most appropriate placement for the minor. Additionally, we interviewed the judicial officers and the county counsel staff, who indicated that adverse decisions occurred very infrequently and were not a significant problem in Kern County.

The Juvenile Court Does Not Always Meet Mandated Hearing Timelines

The ultimate goal of the dependency process is to place children permanently in a safe environment. Ideally, children involved in this process will eventually return to an improved situation in their family homes. However, because many parents fail to overcome their problems, many children cannot be returned. In instances where an alternative long-term placement is required, the minor may be placed in several different foster homes while the juvenile court attempts to implement an appropriate permanent plan. A lengthy court process may add to the degree of stress placed on minors by the dependency process, so the law requires the juvenile court to complete hearings within certain time limits.

The Welfare and Institutions Code and California Rules of Court mandate hearing timelines when a child is detained. Specifically, when the department removes a child, it must file a petition with the juvenile court within 48 hours. Once it receives the petition, the juvenile court must hold a detention hearing within one court day, a jurisdiction hearing within 15 court days of the detention hearing, and a disposition hearing within 10 court days of the jurisdiction hearing. A court day is any day that the court is in session. For the purpose of our report we refer to these requirements as "hearing timelines." Under certain circumstances, the juvenile court can continue these hearings beyond the time limits. However, the law states that in no event should the juvenile court hold the disposition hearing more than six months after the detention hearing. We will refer to this requirement as the "process timeline." If the juvenile court orders family reunification services, they must be terminated after 18 months. Upon termination, the juvenile court must hold a permanent plan

hearing within 120 days. In total, state law requires that the juvenile court implement a permanent plan hearing no later than 22 months after the detention hearing.

Despite required timelines, the juvenile court has no information regarding the length of time cases take to proceed to each hearing.

To accomplish a timely permanent placement for each minor, California statutes encourage child abuse and neglect cases to progress quickly through the early hearings. Since the juvenile court does not maintain an information system, it has no information regarding the length of time cases take to proceed to each hearing. Therefore, to obtain some understanding of how long it takes the juvenile court to proceed to the various hearings, we selected a sample of 20 cases, comprising 178 hearings, and determined whether the juvenile court met the requirements for hearing and process timelines.

Process Timelines

In 2 out of the 20 case files we reviewed, the juvenile court did not reach a final disposition within the required 6 months. One case took 11 months and the other, 12. Both cases proceeded to an initial disposition within 6 months but, due to circumstances out of the juvenile court's control, underwent the hearing process a second time to reach a final disposition. Therefore, it appears that the juvenile court complied with the process timelines in all of the cases we reviewed.

Hearing Timelines

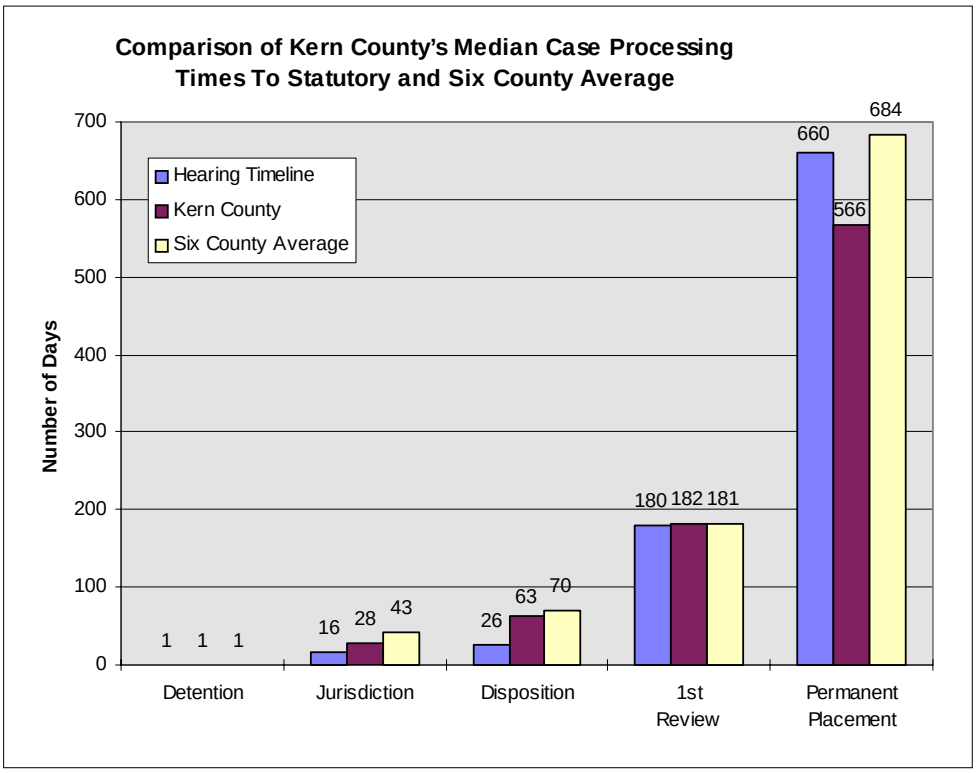
The juvenile court often fails to comply with statutory hearing timelines—at least half the cases exceeded twice the statutory time limit for both the jurisdiction and disposition hearings.

As depicted in Figure 6, the juvenile court often fails to comply with the statutory hearing timelines of up to 16 court days for jurisdiction and up to 26 court days for disposition hearings. At least half of the juvenile court's cases take 28 court days, or nearly twice the statutory limit, to reach the jurisdiction hearing. Additionally, at least half of the juvenile court's cases take 63 court days, or more than twice the statutory limit, to reach the disposition hearing.

The times presented in Figure 6 are measured in percentiles used by the National Center for State Courts to present the same data for six California counties in its *California Court Improvement Project Report*. The amounts in Figure 6 present the 50th percentile for each entity, representing the time it takes for half of the cases studied to conclude the respective hearing: Half of the cases take a shorter time than the median and the other half take a longer time. For example, as depicted for the jurisdiction hearing in Figure 6, the 50th percentile for the juvenile court is 28 court days. That is, it took the juvenile

court less than 28 court days to complete the jurisdiction hearing in half of its cases, and more than 28 court days to complete the other half.

Figure 6



The National Center for State Courts reviewed files from juvenile courts in six California counties to determine the amount of time each court took to reach various dependency hearings. This file review was conducted as part of the *California Court Improvement Project* and included the counties of Butte, Fresno, Humboldt, Los Angeles, San Diego, and San Francisco. This is the best available data regarding case-processing timelines in other California juvenile courts and provides relevant comparisons with the data we obtained from our review of 20 juvenile court cases. The juvenile court is near the six-county average case-processing times for all hearings except for the jurisdiction and permanent plan hearings. It holds the jurisdiction and permanent plan hearings faster than the six-county average.

Despite exceeding statutory timelines, the juvenile court still holds hearings sooner than the six-county average.

The juvenile court is not alone in having problems complying with hearing timelines, as half of the six counties' average cases take 43 court days, or nearly three times the statutory limit, to reach the jurisdiction hearing. Furthermore, 50 percent of the six counties' juvenile court cases take 70 court days, or nearly three times the statutory limit, to reach disposition. One of the reasons the juvenile court does not always meet the hearing timelines is that it often continues hearings to a later date for various reasons.

Continuances Cause Hearings To Exceed Statutory Timelines

The juvenile court may continue hearings several times before they are actually completed. When a case does not progress quickly through the jurisdiction and initial disposition hearings, the juvenile court has difficulty ensuring that permanency decisions are reached as promptly as possible. Although the juvenile court does not track continuances or their causes we found that it granted a continuance in 55, or approximately 30 percent, of our sample of 178 hearings.

Continuances can be granted at any of the hearings and, indeed, we noted continuances granted at all stages of the dependency process. However, the most critical hearings with regard to continuances are the jurisdiction, disposition, and permanent plan hearings. As shown in Table 3, on page 32, at the jurisdiction hearing the juvenile court determines whether the allegations of abuse are true, and at the disposition hearing it determines whether the minor must continue to be detained and orders services be provided to the family. Until these steps are completed, the case cannot progress toward a permanent plan. When permanent plan hearings are continued, the minor remains in the dependency process, which may be stressful to the minor. Additionally, these continuances cause inconvenience for the participants of the hearings, who make arrangements to appear, wait through the day for their hearing, and then receive instructions to come back another day. Of the case files we reviewed, the juvenile court granted continuances in 36 percent of jurisdiction hearings, 31 percent of disposition hearings, and 60 percent of permanent placement hearings. Table 4 shows the percentage of frequency and number of times that these critical hearings were continued.

Table 4

Percentage of Hearings With Continuances
Kern County Compared With Six-County Average

	Percentage of Cases With No Continuances		Percentage of Cases With One Continuance		Percentage of Cases With Two Continuances		Percentage of Cases With Three or More Continuances	
Type of Hearing	Kern County	Six-County Average	Kern County	Six-County Average	Kern County	Six-County Average	Kern County	Six-County Average
Jurisdiction[a]	**64%**[b]	53%	**21%**	24%	**4%**	9%	**11%**	14%
Disposition	**69**	56	**15**	27	**12**	13	**4**	5
Permanent plan	**40**	38	40	**26**	**0**	12	**20**	25

[a] Detention and review hearing data not provided because the National Center for State Courts did not disclose this data for the six counties they reviewed. Therefore, comparisons could not be made.

[b] Boldface percentages indicate superior performance.

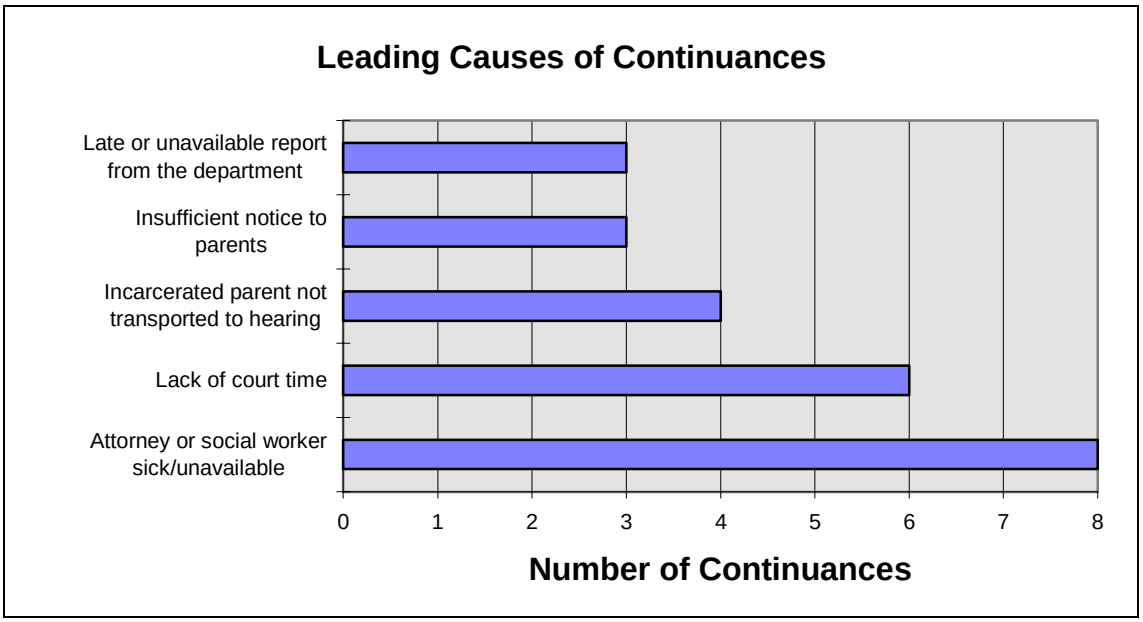
The table also presents comparative data, which was gathered through a sample of case files from the six county juvenile courts as reported by the National Center for State Courts in *California Court Improvement Project Report*.

When compared to information from other counties, the juvenile court in Kern County appears to be at least as effective, if not more so, at limiting continuances.

When compared to continuance information from other county juvenile courts, the juvenile court in Kern County appears to be at least as effective, if not more so, at limiting continuances. The Kern County juvenile court has a smaller percentage of hearings with continuances in every column except for permanent plan hearings with one continuance. Also, the Kern County juvenile court has a greater percentage of hearings with no continuances for all hearing types.

However, continuances are causing the juvenile court to exceed statutory hearing timelines. Figure 7 shows the most common causes of continuances we noted during our review of the juvenile court.

Figure 7



The juvenile court is experiencing the same problems that are causing continuances in other California counties. A survey of judicial officers, attorneys, and social workers conducted by the National Center for State Courts also identified lack of court time, insufficient notice, an incarcerated parent not transported to hearing, and a late or unavailable report as four of the top five factors that cause continuances in dependency cases.

Many continuances caused by late or unavailable reports, insufficient notice to parents, and incarcerated parents not being transported are avoidable.

Due to Kern County's increasing workload and the fact that there is only one judge to hear contested cases at the juvenile court, hearings must often be continued. Also, the illness of attorneys or social workers is unavoidable. However, many continuances caused by late or unavailable reports, insufficient notice to parents, and incarcerated parents not being transported are avoidable.

We noted three continuances caused by the department submitting late reports. Rule 1455(a) of the California Rules of Court requires the department to prepare court reports and recommendations for disposition and submit them at least 48 hours in advance of the hearing. When reports are not submitted on time, the judicial officer and attorneys involved with the specific hearing may not have sufficient time to assess the report information and, therefore, may request a continuance. Some continuances could be avoided if the department submitted reports before the hearing, as required by statute.

We also noted three instances of continuances caused by the department's failure to notify parties of the hearings within the time limits required by law. The juvenile court must verify that this notice has been provided before it can conduct the hearing. When proper notice is not made, the juvenile court must continue the hearing. The department could prevent continuances caused by inadequate notice by ensuring that it properly notifies all involved parties.

Two continuances were caused when incarcerated parents, who had a right to appear at the hearings, were not transported to court. The department must prepare and submit a transport order to the court three weeks in advance of the hearing, but in one instance it failed to secure the order in a prompt manner. A judicial officer from the juvenile court signs the transport order and submits it to the sheriff's office, which forwards it to the California Department of Corrections. The incarcerated parent is then transported to the hearing. If an incarcerated parent does not wish to appear at a hearing, the incarcerated parent must sign a waiver of appearance form. According to the department, in this instance, the social worker initially sent a waiver for the parent to sign; however, the parent did not sign the waiver and decided that he did want to attend the hearing.

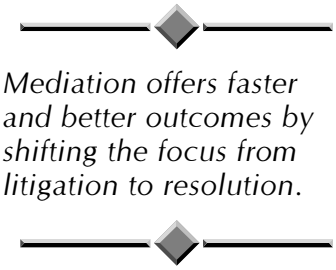
At this point, the department did not have enough time to obtain a transport order, and the hearing had to be continued. To remedy this situation, the department and the juvenile court could implement a plan to automatically issue a transport order for an incarcerated parent to be transported to a hearing unless the parent signs a waiver of appearance. In the other instance, the juvenile court issued an order promptly, but the Department of Corrections failed to transport the incarcerated parent. In our investigation, the presiding judge of the juvenile court stated that this is an increasing problem, resulting in numerous continuances. These continuances could be avoided if the department would obtain transport orders promptly, and the Department of Corrections would transport incarcerated parents according to transport orders issued by the juvenile court.

A Mediation Program Could Reduce Continuances Due to Lack of Court Time

As mentioned above, the second most frequent cause of continuances in our sample of 20 court cases was a lack of court time. The juvenile court has two judicial officers, a judge and a referee. However, generally only the judge initially hears cases contested by one of the parties. Because

contested hearings are often lengthy, other contested hearings have to be continued. To address this problem, the juvenile court should evaluate the feasibility of instituting a mediation program to settle many of these contested matters outside of the courtroom.

The Welfare and Institutions Code, Section 350, encourages each juvenile court to develop a mediation program to provide a problem-solving forum for all interested parties to develop a plan in the best interest of the minor. Mediation programs divert cases from the formal court process, help the parties reach agreement before contested hearings, and negotiate case and permanent placement plans. Mediation offers faster and better outcomes by shifting the focus from litigation to resolution. The American Bar Association Center on Children and the Law states that the presumption that dependency cases will be litigated impedes the successful resolution of these cases in the following ways:



Mediation offers faster and better outcomes by shifting the focus from litigation to resolution.

- Entrenched postures are developed that pit parents against children, agency staff, service providers, and other "family helpers."

- Parents have decreased motivation to correct the problems that led to intervention, since the focus of attention becomes the adversarial process itself.

- Time when the parents and child could be receiving services is lost awaiting the judicial resolution of the case.

- The child, parents, and family suffer increased trauma when the parties are forced to prepare for and participate in the trial process.

Additionally, the Center for Policy Research conducted an independent evaluation of pilot mediation programs in five California counties and issued its report in November 1995. Although the Center for Policy Research stated that the survey had several limitations, it was able to conclude the following about the mediation programs in the five counties:

- Mediation is effective in producing settlements and, taken together, well over 70 percent of the cases mediated at each California dependency court resulted in either a full or partial settlement.

- Mediated plans are more creative than litigated plans, and are more likely to result in the parent acknowledging that he or she needs to cooperate with the service plan and needs help in changing his or her behavior.

- Mediation, especially when routinely used to divert all contested cases from litigation, will produce cost savings.

- The pattern indicates that children in the mediation group spend less time in out-of-home placements relative to control group children.

If a mediation program could divert cases that would have otherwise been contested away from the formal court process, the juvenile court could reduce the number of continuances due to lack of court time and, thereby, reduce its case-processing times.

Turnover of the Presiding Judgeship Creates Instability at the Juvenile Court

The presiding judgeship of the juvenile court has changed six times within the past six years.

During the course of our audit, we noted extensive turnover of the presiding judgeship of the juvenile court. Specifically, the presiding judge of the juvenile court has changed six times within the past six years. Court personnel indicated that the constant turnover was a major problem because it takes approximately six months to a year for a judge to become familiar with the laws and procedures of juvenile court. Turnover renders the juvenile court less efficient and increases the chances of poor decisions. Kern County Superior Court Local Rules state that, to the extent possible, the presiding judge of the juvenile court should remain in that position for at least two years. Also, the California Rules of Court state that the presiding judge of the superior court should assign judges to the juvenile court to serve for a minimum of three years. Commenting on this rule, the Judicial Council stated that not only would a three-year term afford the judge an opportunity to become well acquainted with the total juvenile justice complex, but it would also provide continuity to a system that demands it. The committee further commented that a single judge's involvement over the life of dependency cases is important to help ensure positive results. To increase stability and efficiency, the Kern County Superior Court should consider assigning a judge to this position for a minimum of two or three years.

Kern County Juvenile Court Lacks an Information System

During the course of our audit, we attempted to obtain information on court workload, case-processing times, continuances, and various other information from the juvenile court. However, it does not have an information system and, as a result, does not track any of this information. Lack of historic and current workload information precludes the juvenile court from analyzing the data to determine how effectively and efficiently it is operating. Also, although the results of our sample did not indicate a significant problem, the juvenile court currently does not track chronic causes of continuances or how well it is complying with statutory timelines. Further, if its workload increases, an information system would assist the juvenile court in justifying the need for additional resources.

As previously discussed, continuances are a problem at the juvenile court and contribute to hearings not being completed within statutory timelines. An information system would allow the juvenile court to monitor continuances and address their most frequent avoidable causes. Also, an information system would enable the juvenile court to monitor compliance with statutory timelines and alert the court administrator when cases may exceed timelines.

Conclusion

The juvenile court makes critical decisions regarding the lives of the children that enter its jurisdiction. In our sample of 20 cases, comprising 178 hearings, the juvenile court and the department agreed on the safest and most appropriate placement for the children in all but one instance. Although the juvenile court complies with the statutory process timeline of holding a disposition hearing within six months of the detention hearing, and reaches critical hearings in comparable or better times than juvenile courts in other California counties, it rarely complies with statutory timelines for individual hearings. This is because the juvenile court often continues hearings, which lengthens the time that children must remain in the dependency process. Lengthy proceedings may add to the degree of stress placed on minors by the dependency process. Many of these continuances are not the juvenile court's fault but are, for example, due to late reports from the department, inadequate notice to involved parties, the failure to transport incarcerated parents to hearings, and lack of court time. The juvenile court does not have an information system

and, as a result, does not monitor the number and causes of continuances, its compliance with process or hearing timelines, or its workload. Additionally, the presiding judge position has had extensive turnover, which has caused instability at the juvenile court.

Recommendations

To ensure that its process to provide an appropriate and timely permanent placement to children within its purview is efficient, the juvenile court should do the following:

- Implement an information system that would allow it to
    - ◊ monitor continuances and their causes and take steps to remedy any causes of continuances that are avoidable;
    - ◊ monitor compliance with statutory hearing and process timelines; and
    - ◊ provide other pertinent management information such as court workload statistics.
- Consider implementing a mediation program.
- Consider assigning a presiding judge to at least a three-year term in accordance with local and state rules of court.

To prevent unnecessary continuances and shorten case-processing times, the department should ensure that it submits its reports to the juvenile court at least 48 hours prior to the hearing date, that it submits transport orders promptly, and that it provides adequate notice of dependency hearings to required parties.

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Chapter 3

The California Department of Social Services Should Continue To Improve Its Oversight of Child Welfare Services

Chapter Summary

The results of our statewide survey of child protective services agencies indicate that problems similar to those we identified in Kern County may exist elsewhere in the State. The California Department of Social Services (DSS) could help find solutions for some of these problems by improving its oversight of the State's child welfare services system in the areas of compliance reviews and child death reviews. In the past, the DSS has not conducted timely compliance reviews of the counties' child welfare services programs. Additionally, the DSS did not always monitor the counties' emergency response and administrative practices. Furthermore, the DSS does not track the number of child deaths from abuse or neglect in the State. We believe that statewide leadership by the DSS is critical to the protection of children from continued abuse or neglect.

More recently, the DSS has shown leadership in improving child welfare services programs in certain areas. Specifically, it is leading the efforts to develop a research-based, statewide risk-assessment tool and has established regional training academies as well as initiating other progressive projects.

Many Counties Appear To Have Weaknesses Similar to Kern County's

A lack of consistency in the quality and effectiveness, monitoring of, and controls over, the provision of child protective services exists statewide.

To determine the extent of operating controls that other counties use to ensure that proper services are provided and to obtain the counties' perspectives on child welfare services issues, we surveyed child protective services agencies in all 58 counties. We received responses from 46 counties, and the results indicate that many counties may have weaknesses similar to those we found in Kern County. For example, a lack of consistency in the quality and effectiveness, monitoring of, and controls over, the provision of child protective services

exists statewide. As a result, children in the State may not be adequately protected from caretaker abuse and neglect. Appendix B contains a summary of the responses we received.

Of the 46 counties that responded, 40 indicated they do not have a quality assurance position in their organization that monitors the quality and effectiveness of the services they deliver. Additionally, although it has been proven to be more accurate than other methods, none of the 46 counties are currently using a research-based risk-assessment tool to assist child protection decisions. Furthermore, 40 of the 46 counties responding indicated that they have not identified outcomes by which to measure their effectiveness. Finally, all of the 46 counties indicated that they use some sort of risk assessment to assist social workers. However, 13 counties do not have a management representative review the assessment tool to ensure that it is used properly.

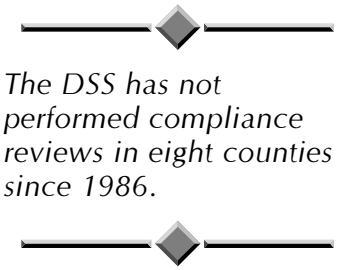
Fourteen counties that responded did not monitor the number of cases their respective social workers carry. Furthermore, 39 counties indicated that they have not developed caseload standards for their social workers to better identify when staff may be overburdened. Adequate monitoring of social worker caseloads is important to appropriately distribute caseloads among workers and to identify when additional resources are needed.

Finally, of the 46 counties responding, 25 indicated they do not have policies and procedures that implement the child welfare services laws and regulations locally. Furthermore, although the 46 counties reported a total of 295 child deaths attributable to abuse or neglect from 1994 through 1996, 20 reported that they did not conduct internal reviews to determine if their policies or practices may require revision. Local policies and procedures are needed to ensure that workers are aware of county goals and priorities in providing child welfare services and are informed of their responsibilities in providing these services.

The DSS Has Not Consistently Performed Timely and Complete Compliance Reviews of County Child Welfare Services

The DSS has not performed compliance reviews of county child welfare services programs on time in the past and has not always included two critical areas of the child welfare services

system: emergency response and county administrative practices. These reviews ensure county compliance with federal and state laws and regulations and also ensure that the local agency is effectively administering its child welfare services program. Without adequate reviews, the DSS cannot assure that counties are providing sufficient child protective services. However, the DSS has recently implemented a plan to monitor counties consistently, including their emergency response systems.



The DSS has not performed compliance reviews in eight counties since 1986.

In our review, we found that the DSS had not performed compliance reviews of 8 out of the 58 counties in the State since 1986, and had not performed 15 since 1993. The United States Code, Title 42, Section 671, requires the DSS to monitor child welfare services programs through periodic evaluations. As a condition of obtaining child welfare services funds, the DSS submits to the federal government an annual plan describing how it will comply with this requirement. In its 1991 plan, the DSS outlined a statewide process wherein it would review each county's program every three years. Internal department documents dating back to 1994 support the DSS's intention to review counties on a three-year cycle. Our review showed it has not reviewed some counties for 10 years.

The DSS's Children's Services Operations Bureau is responsible for oversight of the counties' child welfare services programs. This unit conducts compliance reviews, works with counties to develop corrective action plans, and monitors the counties' efforts to implement the corrective action plans. In addition, it provides technical assistance, consultation, and training to all county child welfare services agencies.

As shown in Table 5, the DSS conducted compliance reviews of all counties in 1986. However, between 1986 and fiscal year 1990-91, the DSS could provide evidence that it performed compliance reviews in only three counties. During fiscal years 1990-91 through 1993-94, the DSS conducted reviews of 18 child welfare services agencies. In fiscal year 1994-95, it conducted 19 reviews and 8 more in fiscal year 1995-96. As a result, 8 counties have not been reviewed since 1986 and another 7 counties, including Kern, have not been reviewed since fiscal year 1991-92.

Table 5

DSS Compliance Reviews of County Child Welfare Services Programs Since 1986

= Reviewed Sched. = Scheduled for Review

[a]Lake County was reviewed twice in fiscal year 1994-95

Over the past few years, the DSS has repeatedly redirected compliance staff to other priorities.

The DSS has not always been able to perform timely compliance reviews because its limited resources have been repeatedly redirected towards higher priorities. For example, in 1993 and 1994, the DSS's compliance staff concentrated its efforts in assisting San Francisco County's development of a corrective action plan after its child welfare services agency was found to be significantly out of compliance. Again in 1993-94, the DSS directed child welfare services compliance staff to successfully defend the State against noncompliance issues alleged by a federal audit and towards development and training efforts for the new Division 31 regulations.

In 1996, a nonprofit child advocacy group filed a lawsuit against the DSS alleging that it was not conducting timely compliance reviews of the county child welfare services agencies. The DSS settled the lawsuit in 1997, agreeing to complete compliance reviews of every county in California no later than June 30, 1998. Additionally, the DSS agreed to perform compliance reviews of every county no less than every four years prior to the Child Welfare Services/Case Management System (CWS/CMS) becoming operational in that county and no less than every three years thereafter.

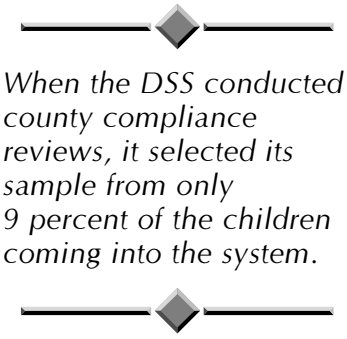
In March 1997, the DSS issued a comprehensive oversight plan to the counties in the form of an all-county letter. The plan, consistent with the settlement agreement, detailed the DSS's goal of reviewing all counties it had not reviewed since fiscal year 1994-95 by June 30, 1998. Currently, the DSS is on track with its schedule, completing 20 compliance reviews during fiscal year 1996-97.

The DSS Should Include Critical Components of the Counties' Child Welfare Services System in Its Reviews

The DSS does not always review the adequacy of the counties' emergency response systems or their administrative practices. Although we did not find any law or regulation that required the DSS to include these specific areas in its reviews, we feel that doing so would increase the quality and effectiveness of child protective services in the State. By failing to consistently review these areas, the DSS cannot evaluate the total effectiveness of a county's child welfare services program. As a result, the DSS may not detect inadequate emergency response services or improper administrative practices. If counties are operating inadequately, they may not be protecting children from abuse and neglect.

The DSS Does Not Always Review the Emergency Response System

Until fiscal year 1993-94, the DSS included the counties' emergency response system in its compliance reviews. However, in fiscal year 1993-94 the DSS began developing new child welfare services regulations as well as a new compliance review tool that measured compliance with the new regulations. Although the DSS included one question regarding the emergency response system in its revised compliance review tool, prior to 1996 it did not always include cases from the emergency response system in its sample of cases it reviewed. If the DSS does not review the emergency response system as part of its monitoring process, it cannot ensure that referrals into this key stage of child protective services are being handled appropriately by the counties.



When the DSS conducted county compliance reviews, it selected its sample from only 9 percent of the children coming into the system.

Each county is mandated to have an emergency response service component that receives and assesses reports of abuse and neglect and determines if an in-person response is necessary. If the county makes an inappropriate decision at this critical stage, it could expose children to additional abuse or neglect. Between fiscal year 1993-94 and January 1996, when the DSS conducted a compliance review it normally selected its sample from cases transferred to the Family Maintenance, Family Reunification, and Permanent Placement components of the child welfare services system. However, these cases represent only 9 percent of the children coming through the emergency response system. Therefore, the DSS did not consider the remaining 91 percent of the children whose cases were closed at the emergency response stage without receiving these services.

Because the DSS has not always reviewed the emergency response component of counties' child welfare services operations, it could not assure that the counties were adequately following regulations aimed at protecting the lives of children at risk of abuse or neglect. If a county is not conducting its emergency response system optimally, social workers may inappropriately close cases and leave a child in a potentially dangerous situation.

The DSS has stated it has included emergency response reviews as part of its comprehensive monitoring approach since January 1996. This review addresses several critical areas, including whether the county considered prior referrals, documented all the risk factors, made contact with the child within the required time frame, called all available collateral contacts, and notified all mandated reporters of the outcome of their referrals.

The DSS Does Not Evaluate County Administrative Practices as Part of Its Compliance Reviews

The DSS does not evaluate child welfare services administrative practices and therefore cannot ensure that counties are effectively and efficiently managing these resources. As discussed in Chapter 1, our review of the department found several administrative problems in Kern County's child welfare services program. For example, we found that the county did not have a current procedures manual for its employees, nor did it have an effective method for monitoring social worker caseloads. Responses to our surveys indicate that administrative problems are not unique to Kern County. We found that 25 of the 46 counties responding to our survey indicated they did not have a policies and procedures manual that spells out how they will implement state regulations locally. Our survey also showed that some counties do not have a means to track social worker caseloads.

Twenty-five of the 46 counties responding to our survey indicate they lack a manual spelling out how to implement state regulations locally.

In addition, in 1995 and 1996, respectively, the Child Welfare League of America (CWLA), reviewed Humboldt and Riverside counties' emergency response functions and reported they lacked adequate policies and procedures manuals. Such manuals can provide needed guidance to emergency response staff on processes and practices. In one of these reports, the CWLA states that most emergency response workers it interviewed said that manuals on county policies and procedures would be enormously helpful in providing guidance to them and increasing accountability.

The DSS acknowledges that it does not routinely include administrative reviews of county child welfare services agencies as part of the child welfare services program oversight process. It indicated that if, in the process of performing its compliance review, it identifies strengths or weaknesses, this information is discussed in the compliance report. However, this current method of reviewing county administrative systems is inadequate because the DSS does not examine the administrative system unless a problem is obvious. In addition, since the DSS has not performed a compliance review in some counties for well over five years, it would not be aware of administrative problems in these counties. Finally, the DSS indicated that its newly implemented statewide case management system will provide it with the ability to monitor some county administrative practices, such as the social worker caseloads.

The DSS Does Not Know the Extent of Child Deaths Attributable to Abuse and Neglect in the State

The DSS does not know the extent of deaths caused by child abuse or neglect throughout the State because counties are not required to report them. It becomes aware of these deaths only through contacts with counties or through other sources, including the media, the public, and local agencies. Existing databases on child deaths within the State are not reliable sources of child abuse and neglect deaths because they were established for different purposes. Without this information, the DSS cannot identify systemic weaknesses in county child welfare services, and its ability to consider regulatory or legislative changes to reduce the risk of abuse and neglect to children is hindered.

Without child death information, the DSS cannot identify systemic weakness in services and its ability to introduce changes to reduce risks of abuse and neglect to children is hindered.

According to a 1997 report by the California Attorney General's Office titled *Child Deaths in California*, three existing databases provide totals for child deaths in the State: Vital Statistics Death Records, maintained by the Department of Health Services (DHS); and the Homicide File and Child Abuse Central Index (CACI), both maintained by the Department of Justice (DOJ). The databases do not adequately report deaths due to child abuse throughout the State because they were originally set up for different reporting purposes. For example, the Vital Statistics Death Records was established to track the types of deaths based on death certificates. Although the CACI should have the most accurate data because it tracks alleged reports of child abuse and neglect as reported by law enforcement and child protective services in the State, it is unreliable because agencies do not always report child abuse cases to the CACI. Between 1992 and 1995, total child abuse fatalities of children under age six were reported by the three databases as 396, 211, or 259, respectively.

The California Penal Code, Section 11166.9, authorized the DOJ to coordinate and integrate state and local efforts to address fatal child abuse and neglect and to create a body of information to prevent child deaths. The DOJ, in turn, established a State Child Death Review Board (board), partially composed of representatives from the DSS, the DHS, the DOJ, and the Office of Criminal Justice Planning (OCJP). The board's purpose is to promote and sustain county teams and provide them with technical assistance and training. Its responsibilities include training county death review teams, collecting data, and reporting. However, reviewing child death cases is not included in the role of the board. The California Penal Code,

Section 11166.7, allows for the creation of voluntary local child death review teams. These teams assist local agencies in identifying and reviewing suspicious child death cases.

Several new laws should provide more information pertaining to child deaths from abuse and neglect.

In an attempt to address the need for information pertaining to child deaths from abuse and neglect, the Legislature enacted several new laws during the 1997-98 legislative session. Among them, SB 644 renames the Child Death Review Board to the Child Death Review Council, expands access to the CACI to out-of-state law enforcement and review teams, and requires the state and local death review teams to reconcile the three databases described above as it relates to child fatality cases. The governor recently signed into law AB 67, which requires the DSS to work with state and local child death review teams in assessing which child deaths were known or should have been known to the counties' child protective services agencies. As part of AB 67, the DSS, the DHS, and the DOJ were required to submit a plan to the Legislature by December 1, 1997, describing how it will fulfill this requirement. The DSS submitted this report to the Governor's Office December 1, 1997.

Also, in fiscal year 1996-97, the DOJ, in collaboration with the DHS and with funding from an OCJP grant, created a child death reporting form and developed a pilot project in seven counties throughout the State. The project requires review teams to complete a child death review questionnaire and submit it to the DHS, which analyzes trends. Although the form will collect data for all types of child deaths, review teams will indicate on the form if the death was attributable to abuse or neglect. Additionally, review teams will also indicate whether the victim or the victim's family was known to child protective services.

According to the DHS, it suspended the project when the three-year grant ended June 30, 1997. It further stated that although pilot counties continue to submit data, the DHS has been able to analyze only six months of data. Finally, as of late November 1997, the DHS has initiated the redirection of funds to continue the pilot data collection and extend it to additional counties. This short-term action is intended to keep the project going until stable funding can be identified. The board and involved state agencies are meeting to obtain funding on a long-term basis.

It appears that this pilot project addressed the problem of a lack of reporting of child deaths due to abuse or neglect. However, because it was suspended, its potential effectiveness has been hampered. If the project were continued and expanded, the

DSS could gather data on child deaths attributable to abuse and neglect and use it to compile statewide information, analyze trends, evaluate the need for policy and legislative changes, and better regulate the State's child welfare services system.

The DSS Has Developed Several Initiatives To Provide Leadership to the Child Welfare Services Community

The DSS has done more to provide leadership for statewide child welfare services in the recent past. Examples include developing a statewide risk-assessment tool, establishing regional training academies for county social workers, and initiating pilot projects in the areas of home visiting and family preservation.

In early 1995, the DSS began actively pursuing a statewide research-based risk assessment tool. A research-based risk-assessment tool is supported by studies on actual cases, whereas a consensus-based risk-assessment tool is supported by the consensus opinion of many professionals.

Based on a comparison of several research studies and on risk-assessment tools used in some other states, a research-based risk-assessment tool is typically more accurate than other methods. Use of a research-based risk-assessment tool will assist the counties in assessing a child's risk of future abuse or neglect. It also will ensure that cases with the most risk receive the most intense services. However, most counties in the State do not use a research-based risk-assessment tool. In fact, as shown in Appendix B, none of the 46 counties responding to our survey indicated that they used this.

The DSS has proposed a pilot project to test a research-based risk-assessment tool in seven counties.

In early 1996, the DSS met with county child protective services staff to discuss the merits of a research-based statewide risk-assessment tool. In June 1997, the DSS proposed to pilot a child welfare services structured decision-making system. The proposed model, which will include a research-based risk-assessment tool, will be piloted at seven counties representing over 65 percent of the State's child protective services population. This structured decision-making model has been subjected to testing in Michigan, and the results indicated a reduction in recidivism and out-of-home placement. The DSS is in the process of establishing a contract with a vendor to pilot this program in California. However, as of the end of our fieldwork, the DSS had not finalized the contract.

The DSS, in collaboration with the County Welfare Directors Association, has also facilitated the establishment of five regional training academies throughout the State. These academies strive to provide uniform, competency-based training to child welfare services staff throughout the State by offering courses in areas such as human development and behavior, assessment skills, case planning and coordination, and intervention skills and techniques.

In addition to the risk assessment project and the regional training academies, the DSS has initiated several other projects that address home visits and family preservation in an effort to reduce the incidence of child abuse and neglect through prevention. The home-visiting program makes contact with at-risk families before abuse actually occurs. The family preservation program provides families with intensive community services to better deal with parenting. It strives to preserve the family unit and attempts to keep children out of foster care or adoption.

Conclusion

Based on the results of our survey, it appears as though many county child protective services agencies have weaknesses in their operations similar to those identified at Kern County. Weaknesses related to consistency in the quality and effectiveness, monitoring of, and controls over, child protective services being provided were noted in a number of responses. As a result, children in the State may not be adequately protected from caretaker abuse and neglect.

The DSS has not conducted timely compliance reviews of the counties' child welfare services programs, and when it did review a county, the DSS did not always include the emergency response services or administrative practices. These reviews are important to help ensure that counties are protecting children from abuse and neglect. The DSS has recently developed a plan to review each county at least every three years and to include the emergency response services in its scope. This plan, if fully implemented, would address most of the concerns we have with the DSS's monitoring. However, it still does not include the administration of county child welfare services programs in its reviews.

Additionally, the DSS is not currently able to determine the number of child deaths occurring in the State due to caretaker abuse or neglect or to properly analyze the deaths to detect potential county or systemic problems, because of an inadequate reporting system. A reporting system that would

provide the information the DSS needs to compile and analyze this information has been developed by the DHS; however, due to a lack of funding, the pilot project under which the system was created has been suspended.

Recently, the DSS has provided some leadership over county child welfare services programs. For example, it has initiated a collaborative effort with seven counties to pilot a structured decision-making model that includes a research-based risk assessment, regional training academies, and home-visiting and family preservation projects, among others.

Recommendations

To strengthen its leadership role and improve its oversight of the State's child welfare services, the DSS should do the following:

- Continue with its schedule to review each county for compliance at least once every four years until it completes the implementation of its statewide automated child welfare services system, and every three years thereafter.

- Review county emergency response systems and administrative practices as part of its comprehensive monitoring approach.

- Continue to provide leadership to county child welfare agencies through progressive child welfare initiatives.

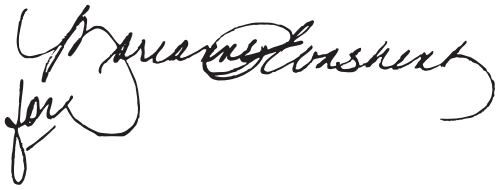
To ensure that the State is able to better identify trends and county and statewide systemic child welfare services weaknesses, the Legislature should consider the following:

- Continue the pilot project initially started to establish a standardized child death reporting form.

- Require the appropriate state agency to establish a statewide child abuse and neglect fatality database using the processes developed by the pilot project.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



KURT R. SJOBERG
State Auditor

Date: January 15, 1998

Staff: Elaine M. Howle, CPA, Audit Principal
David E. Biggs, CPA
Phillip Burkholder, CPA
David C. Hawkes, CPA
Milton Torres, CPA

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Appendix A

Child Death Cases Attributable to Caretaker Abuse or Neglect in Kern County Since 1995

Date	Summary of Case
03/95	A ten-week-old boy died from allegedly being shaken by his father. The department had no prior contact with or referrals for this family.
05/95	An eight-month-old girl died as a result of alleged abuse she received from her parents. The department received a referral for this family three months prior to the child's death. The department's investigation substantiated neglect, and the social worker recommended family maintenance services. However, when the social worker discussed the case with a supervisor, the supervisor decided that services would not be appropriate, and the case was closed.
09/95	A seven-year-old boy died as a result of physical abuse allegedly received from his mother's live-in boyfriend. The department had received four referrals for this family prior to the child's death. All of the referrals were received by the department prior to the mother's boyfriend moving into the family's home. The department's internal review concluded that it did not properly use its risk assessment tool on any of the prior referrals, and that in at least three of the referrals, if the risk assessment tool had been used appropriately, the department could have intervened on behalf of the child.
01/96	A three-month-old girl died as a result of severe neglect and malnutrition. The department responded to a referral less than two months before the child's death; however, the social worker found the home to be clean and to have adequate food for the health and safety of the children.
05/96	A three-year-old girl died as a result of alleged physical abuse from her mother and her mother's live-in boyfriend. The department had prior contacts with this family; however, they were prior to the birth of the child.
05/96	A two-year-old girl died as a result of physical abuse allegedly received from her mother and her mother's live-in boyfriend. The department received a referral for this family a month before the child's death. Although it alleged that the child had recent bruises, the boyfriend was a gang member and a drug user, and the mother abused drugs, the referral was coded as general neglect rather than physical abuse and was

Date	Summary of Case
	determined inappropriate for response. The department's internal review of the case concluded that the referral met the legal definition of abuse or neglect and should have been investigated by a department investigator. The department further concluded that the risk assessment tool was not used effectively and that the screening of the referral was not completed adequately.
07/96	A seven-month-old boy died as a result of abuse allegedly received from his mother's boyfriend. The department had no prior contact with or referrals for this family.
10/96	A four-year-old boy died as a result of physical abuse allegedly received from his mother's live-in boyfriend. The department received a referral for the family one month prior to the child's death and determined it inappropriate for in-person response. A copy of the referral was forwarded to the Bakersfield Police Department by fax. However, the police did not act upon the referral until three weeks after the department had received it and were unable to locate the family until after the child had been killed. The department's internal review determined that it should have investigated the referral. Not only did it merit an investigation because the victim was under age five, but the allegation also indicated a high-risk situation that would merit a response. As a result of this case, the department revised its policies and disciplined the employee involved.
11/96	A four-month-old girl died allegedly as a result of "shaken-baby syndrome." The department had received one prior referral on this family; however, it was prior to the child's birth and did not relate to the family's care for the child.
01/97	A 16-month-old boy died as a result of ingesting over 20 iron tablets. The department had received one prior referral about this family in 1992 related to possible sexual abuse, but after physical examinations were conducted, the referral was determined to be unsubstantiated.
01/97	A two-month-old girl died as a result of allegedly being physically abused by her aunt. The department had received a referral on this family six weeks before the child's death. However, the referral did not include allegations of abuse and when investigated the referral was determined to be unfounded.

Appendix B

Summary of Responses to County Child Protective Services Survey

A. County Policies and Procedures

1. Twenty-five out of 46 counties indicated that they did not have written policies or procedures that implement CWS laws and regulations.

2. None of the 46 counties reported using a research-based risk assessment model.

3. All 46 counties indicated that they use some sort of risk assessment tool. Thirty counties use it at the emergency response stage of their child protective services, 11 in the court intake phase, 9 in the family maintenance and reunification stages, and 8 in the permanent placement stage.

4. Thirteen of the 46 counties indicated that completed risk assessments are not reviewed and approved by management representatives.

5. Forty-one of the 46 counties use a checklist in their emergency response phone rooms to obtain referral information.

6. Only 1 of the 46 counties reported having a policy or practice making caretaker drug use, in and of itself, a basis for removing children from a home.

7. Forty of the 46 counties do not have a quality assurance position or unit that monitors the quality and effectiveness of services being delivered.

8. Forty of the 46 counties have not identified specific outcomes by which they can measure effectiveness or success.

9. On a scale of 1 to 5, 1 being not important and 5 being very important, the 46 counties on average rated child protection as 4.98 and family reunification as 4.67.

B. Community Support/Involvement

1. Sixteen of the 46 counties do not have a community advisory board that provides community input and guidance to the county child protective services department.

2. Seven of the 46 counties do not use community-based organizations to provide services to families.

3. Only 3 of 39 counties reported the confidential nature of referrals as a problem in referring cases to community-based organizations for services. Seven counties did not answer this question.
4. Ten of 39 counties do not have a process to ensure that families referred to a community-based organization actually receive services. Seven counties did not answer this question.

5. Thirty of 39 counties reported experiencing difficulties accessing appropriate services for families due to waiting lists or overburdened service providers. Seven counties did not answer this question.

C. Child Deaths

1. Only 3 of the 46 counties do not have a child death review team.

2. Twenty of 45 counties do not have an internal review team within their child protective services departments that review child deaths attributable to neglect or abuse and identify policies or procedures that could be improved. One county did not respond to this question.

3. Thirty-eight counties reported a total of 295 child deaths resulting from caretaker abuse or neglect from 1994 through 1996. (One of these counties reported such deaths only for 1994 and 1995.) Eight counties did not answer this question.

4. Of the 71 child deaths reported for 1996, 19 of the families had been previously referred to the county. Twelve counties did not respond to this question.

D. Access to Information

1. Prior to the recent implementation of the statewide child welfare services case management system, phone room workers in 7 of the 46 counties did not have ready access to an information system that included past child abuse and neglect experiences of victims and perpetrators.

2. Several counties reported using information sources, such as the Department of Motor Vehicles and Aid to Families with Dependent Children, to assist in their child protective services efforts.

3. Twenty-three of 43 counties reported databases or other information sources they do not currently have access to that would be useful in their child protective services. Two counties did not respond to this question, and 1 responded that it did not know.

4. Some of the systems the counties are not able to currently access include the Criminal Justice Information System, the Child Abuse Central Index, and Probation.

E. Social Worker Workloads

1. Fourteen of the 46 counties do not have a method for monitoring the workload of their social workers.

2. Thirty-nine of 46 counties have not established local caseload limits or standards.

3. The average caseload for the child protective services social workers (expressed in number of children served) by section and the number of counties responding to each section were as follows:

a.	Emergency Response investigation	32.4	(29 counties)
b.	Court Intake	17.3	(27 counties)
c.	Family Reunification	27.5	(24 counties)
d.	Family Maintenance	32.4	(25 counties)
e.	Permanent Placement (including adoptions)	46.0	(29 counties)

4. The following are the average numbers of workers the counties reported are currently working in each child protective services section and the number of counties responding to each section:

a.	Emergency Response investigation	31.2	(33 counties)
b.	Court Intake	12.0	(30 counties)
c.	Family Reunification	19.5	(23 counties)
d.	Family Maintenance	14.5	(23 counties)
e.	Permanent Placement (including adoptions)	26.1	(28 counties)

5. The following are the average turnover rates of social workers that the counties reported by section in 1996 (expressed in number of social workers who left their positions) and the number of counties responding to each section:

a.	Emergency Response investigation	1.70	(33 counties)
b.	Court Intake	0.70	(30 counties)
c.	Family Reunification	1.86	(28 counties)
d.	Family Maintenance	0.57	(28 counties)
e.	Permanent Placement (including adoptions)	0.78	(32 counties)

6. Eight of the 46 counties reported that the same social worker handles a case as it proceeds through Emergency Response, Court Intake, Family Reunification, Family Maintenance, and Permanent Placement. Thirty-seven counties report that different social workers handle the cases, and one county indicated that it did both.

F. Miscellaneous

1. All 46 counties reported providing continuing education or training opportunities to their social workers.

2. Thirty-eight of the 46 counties indicated that they normally use law enforcement personnel to detain a child rather than using child protective services staff.

3. Only 20 of the 46 counties have temporary receiving homes to house children taken into protective custody.

4. The 20 counties that have temporary receiving homes estimate that on average these facilities are used at 86 percent of capacity.

5. The range of lengths of time services are provided to children or caretakers in each child protective services section and the number of counties responding to each section were as follows:

a.	Emergency Response investigation	8 hours to 1 year	(24 counties)
b.	Court Intake	72 hours to 4 years	(24 counties)
c.	Family Reunification	12 to 18 months	(24 counties)
d.	Family Maintenance	6 months to 2 years	(25 counties)
e.	Permanent Placement	18 months to 9 years	(23 counties)

G. Views of Local and Statewide Child Protective Services

1. On a scale of 1 to 10, 1 being minimal and 10 being significant, the counties on average reported the extent that opinions and decisions of the Juvenile Court judicial officers influence their policies and procedures enacted was a 7.

2. On a scale of 1 to 10, 1 being low and 10 being high, the counties on average reported the following:

   a. Community support of child protective services was a 6.
   b. Community approval of child protective services was a 6.
   c. Compliance by mandated reporters in reporting instances of child abuse and neglect was a 7.

3. On a scale of 1 to 10, 1 being poor, 10 being excellent, the counties on average reported:

   a. The effectiveness of cross-reporting between child protective services and other entities as follows:
      (1) Law enforcement was a 7.
      (2) Medical personnel was a 6.
      (3) School or day care personnel was a 7.
   b. The leadership received from the State's Department of Social Services related to child protective services was a 5.
   c. The oversight received from the State's Department of Social Services related to child protective services was a 5.

4. Ten counties did not support a uniform statewide risk assessment document such as the one the State's Department of Social Services is currently developing.

KERN COUNTY
DEPARTMENT OF HUMAN SERVICES
100 E. California Avenue
Bakersfield, CA 93307

January 8, 1997

Kurt R. Sjoberg, State Auditor
Bureau of State Audits
660 J Street
Sacramento, CA 95814

Dear Mr. Sjoberg:

On behalf of the Kern County Department of Human Services, I would like to thank you for the opportunity to prepare a written response to the draft of the State Auditor Report received January 2, 1998. We appreciate the time and effort that your audit team dedicated to the review of the Department of Human Services.

Sincerely,

Donald E. Dudley
Director

Kern County Department of Human Services' Response to the California State Auditor's Report

Kern County Human Services welcomed this audit and worked closely with the auditors to provide the requested information. We opened all our records and spoke candidly with the audit team. Most of the audit findings are not new information for Human Services management - these system weaknesses had become apparent during the period of time that the number of investigations performed was rising rapidly. In 1997, Human Services conducted 22,679 investigations - an 83% increase over the previous year. We have been working continually to balance process and paperwork with the practice of social work to provide protection to children.

We are disappointed that the scope of the audit did not include strengths of our system, which we feel include a critical incident review process, a successful public education campaign, an extensive training program for social workers, and innovative collaborations with other community agencies. Nor did the audit note that no Kern County children have died as the result of abuse since January, 1997.

Kern County Puts the Highest Priority on Conducting In-Person Investigations

Despite the fact that caseloads are four times higher than California Department of Social Services standards, key compliance rates are high. In the cases reviewed:

- 100% of the children deemed to need an in-person response were investigated for risk.
- 100% of the children suspected to be in immediate danger were seen within hours.
- 85% of the low-risk cases were seen within the required 10 days.
- 92% of cases in 1997 had a completed risk assessment form.
- 92% of the cases assigned for investigation had appropriate collateral contacts.
- 84% of the cases requiring feedback to mandated reporters had such feedback documented.

We concur in general with the audit findings, including those related to supervisory review and oversight. Changes have already been made - the dedication of a supervisor in the phone room provides for improved screening and case assignment procedures. We also agree there were difficulties with paperwork completion, resulting in a backlog of low-risk cases that had been investigated and determined to need no further action. These lacked only the written investigation report and/or supervisor review required for closure. The audit acknowledges that the dramatic increase in referrals over the past few years has contributed to these problems.

A New Statewide Automated System Meets a Critical Need

We believe these weaknesses were related to cumbersome paper case record keeping and the rudimentary interim data collection system in place at the time of the review. We also believe the new statewide automated Child Welfare Service Case Management System (CWS/CMS) is precisely the tool the department has needed to address these issues. The system has been in use since September, 1997, and is supplemented with a departmental written guide providing detailed instructions to ensure the system is being used appropriately in assigning cases and monitoring caseloads. Intensive effort was expended prior to CWS/CMS implementation to eliminate the backlog of cases and ensure that accurate, up-to-date information was supplied for the new system. CWS/CMS is functional in all the department's child welfare programs, from Emergency Response to Adoptions.

The automated system will:

- Ensure completion of decision support checklists (required screens must be completed to proceed with referral-taking).

- Enable supervisors to monitor unit caseloads.

- Enable supervisors to monitor the status of individual cases, ensuring the completion of required activities.

- Automate completion of various notices and forms such as mandated reporter feedback notices, hearing notices, and prisoner transportation notices.

Kern County Human Services is Developing a Plan to Strengthen Child Welfare Programs

In addition to implementing the recommendations of the audit, the Department's plan includes:

- Ensuring that written policies are continuously reviewed and updated as needed, workers continue to be informed and trained to comply with current policy, and that compliance is monitored by supervisors.

- Dedicating additional management to ensure oversight at critical points.

- Requesting the Child Welfare League of America submit a proposal to assist in the development of performance and outcome management standards.

- Continuing to develop innovative programs to address the increasing number of

referrals and to efficiently and effectively conduct increasing numbers of investigations.

We will use the recommendations of this audit and every available resource to strengthen our programs and improve our level of service. The Kern County Department of Human Services is dedicated to protecting and serving the Kern County children most in need.

The Superior Court of the State of California
County of Kern
1415 Truxtun Avenue
Bakersfield, California 93301
805/861-2437

January 8, 1998

Mr. Kurt R. Sjoberg
California State Auditor
State of California
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Sjoberg:

The following is in response to your department s audit and report on the operations of the Dependency Court, County of Kern.

Chapter 2: The Juvenile Court Can Improve Its Process of Adjudicating Child Abuse and Neglect Cases.

The report indicates that the Juvenile Court could improve its calendar management specifically with respect to continuances for interim hearings in dependency cases. While it is agreed that improvements can always be made, the information in your report demonstrates that the Kern County Juvenile Court is managing the increasing workload very effectively; and in most cases, is superior to other comparison counties in its handling of juvenile matters.

- Table: Percentage of Hearings with Continuances.

  The table reveals that Kern County is superior in performance to the comparative counties in the timeliness of hearings with the exception of Permanent Plan Hearings With One Continuance.

- Table: Leading Causes of Continuances.

  Only six of the continuances, or approximately 25% of those cited in the report, are within the control of the Juvenile Court. It is anticipated that planned mediation efforts will improve this controllable area of continuances.

- Table: Comparison of Kern County's Median Case Processing Times.

  The Kern County Juvenile Court's ultimate goal is the timely resolution of a juvenile dependency case. The resolution of a juvenile dependency case is the point when an action is dismissed or the point when a permanency placement occurs. Kern County Juvenile Court completes these hearings on an average of 566 days. The Kern County average is 94 days less than the recommended statutory hearing time lines and 118 days less than the six county

average. While in some cases the interim hearings do exceed recommended time lines due to legitimate hearing continuances, Kern County is successful at bringing more cases to quicker resolution than the statutory benchmark or other comparative counties are achieving.

Recommendations:

1) Implement an information system.

The Juvenile Court, in conjunction with County of Kern Information Technology Systems Department, had initiated the development of an automation project for juvenile case management in the second quarter of 1997. The juvenile case management system will be an integrated software program based on the county's successful Criminal Justice Information System (CJIS). The Juvenile CJIS program will allow all applicable agencies with the appropriate access requirements to monitor the status of ongoing dependency cases.

The staff at the Juvenile Court have been directly involved with the development of the project which is anticipated to be on-line by the second quarter of 1998. The information and management reporting capabilities of the Juvenile CJIS program will be reviewed to determine its ability to track and monitor continuances. If program modification is required, the changes will be requested to be completed as quickly as programming and financial resources allow.

2) Consider implementing a mediation program.

The development and implementation of a mediation program for the Juvenile Court is currently under consideration. The Senior Juvenile Referee and staff have been tasked with reviewing mediation programs from other counties and developing a mediation plan for consideration by the judicial officers of the Superior Court.

It is anticipated that the implementation of a mediation plan can be accomplished as early as the fall of 1998. In advance of the overall mediation plan, a meet and confer process will be established. The meet and confer process will facilitate the review of issues in pending contested matters. The meet and confer process will be designed to reduce the number of contested issues in advance of the hearing. This will reduce the anticipated hearing time and increase the available court time for other contested matters cited in your report as a reason for hearing continuances.

3) Consider assigning a presiding judge to at least a three-year term.

The current Presiding Judge of the Juvenile Court has been assigned to his second term effective January 1998 per our local rules of court (Rule 1.31). The local rules of court, inclusive of the recommended term for the Presiding Judge of Juvenile Court, were adopted in July of 1996. Further, given the increased workload at the Juvenile Court, including the 48% increase in dependency filings over the last year, an additional judge has been assigned to the Kern County Juvenile Court to ensure the continued timely resolution of juvenile matters.

Additional Comments:

(Page 2-9) Prison Transportation Problems: The Kern County Juvenile Court has initiated a meeting with the appropriate agencies to review possible solutions for the transportation problems cited as one of the reasons for court hearing continuances. A summit of involved agencies will be held this month to review possible solutions to delays caused by transportation problems. Participants will include the Department of Corrections, Kern County Sheriff, Department of Human Services and the Court.

(Page 2-11) Judicial Turnover: There is no substantiation that judicial turnover results in "poor decisions." The Court is complying with local rules of court recommendations on the assignment of judges at Juvenile Court to ensure continuity of judicial supervision of cases. (1)*

Thank you for the opportunity to respond.

Yours Truly,

Jerold L. Turner
Presiding Judge
Juvenile Court

*The California State Auditor's comments on this reponse begin on page 73.

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Comments

California State Auditor's Comments on the Response From the Kern County Superior Court

To provide clarity and perspective, we are commenting on the Kern County Superior Court's response to our audit report. The numbers correspond to the numbers we have placed in the response.

(1) The conclusion that turnover in the presiding judgeship renders the juvenile court less efficient and increases the chances of poor decisions was based on findings made by the National Center for State Courts in its June 1996 Washington Juvenile Court Improvement Project final report.

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Response to the report provided as text only

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY PETE WILSON, Governor
DEPARTMENT OF SOCIAL SERVICES
744 P Street
Sacramento, California 95814

January 12, 1998

Kurt R. Sjoberg
State Auditor
Bureau of State Audits
660 J Street, Suite 300
Sacramento, California 95814

Dear Mr. Sjoberg:

Thank you for allowing us to comment on the draft of your audit report entitled "Kern County: Has Management Weaknesses at Critical Points of Its Child Protective Process, Which May Also be Pervasive Throughout the State." We have reviewed this draft and we substantially agree with the recommendations for the California Department of Social Services. We would like to make comments to provide clarification on a few areas.

Your auditors devoted a considerable portion of their review on events that occurred in the late 1980s and early 1990s although regulatory requirements, monitoring tools and CDSS and counties practices have changed considerably since that time. (1)*

We are pleased that the report recognizes the department's efforts to strengthen the State's child welfare system. The CDSS will continue to provide leadership toward a progressive child welfare system. Efforts will be focused on six key areas: prevention, program training and staff development, risk assessment, family centered services, permanency, and computerization.

Of note is that most of the recommendations for the CDSS are already included as part of the State's current Children Welfare Services (CWS) program oversight process. The October 1992 update to the Title IV-B State Plan commits the department to a four-year cycle for county reviews. The current review cycle of all 58 counties utilizing the Division 31 regulations began in September 1994 and will be completed by June 1998. Additionally, the CDSS has included a review of the counties Emergency Response component since 1986. This includes a sample of cases that were both opened and closed during emergency response. And finally, we believe that the implementation of a risk assessment and structured decision model will result in improved and more consistent county administrative practice. (2)

We appreciate your recommendations to the Legislature to strengthen the information base on child deaths from abuse and neglect. While more information is needed for both policy makers and administrators, I believe changes will be needed beyond the recommendations you make to assign responsibilities more specifically at both the state and local levels.

*The California State Auditor's comments on this reponse begin on page 77.

We believe that your report will be very useful in our continuing efforts to improve child welfare services and hope that you will consider this response when drafting the final version. Should you have any questions or need further information, please feel free to contact Marjorie Kelly, Deputy Director, at 657-2614.

Sincerely,

ELOISE ANDERSON
Director

Comments

California State Auditor's Comments 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' (DSS) response to our audit report. The numbers correspond to the numbers we have placed in the response.

(1) The DSS is missing the point. While it has conducted sporadic compliance reviews since 1986, the DSS has only recently implemented a schedule which ensures that each county is reviewed timely. Furthermore, while we agree that regulatory requirements, the DSS's monitoring tools, and county practices have changed considerably, these changes do not release the DSS from its responsibility to monitor county child protective services. Indeed, this changing environment makes timely and complete compliance reviews even more important. Moreover, as stated on page 47 of our report, the DSS has not reviewed 8 counties since 1986, and 15 since 1993. Therefore, to report the most recent compliance reviews that the DSS performed for some counties, we had to include reviews that occurred in the late 1980's.

(2) The DSS is incorrect. As stated on page 50 of our report, the DSS included the emergency response component of county child protective services agencies in reviews it conducted prior to fiscal year 1993-94. However, between fiscal year 1993-94 and January 1996, the DSS did not always include the emergency response component in its compliance reviews. Since January 1996, the DSS has included the emergency response component in its comprehensive monitoring approach.

cc: Members of the Legislature
Office of the Lieutenant Governor
Attorney General
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps