Los Angeles County Department of Children and Family Services

It Has Not Adequately Ensured the Health and Safety of All Children in Its Care

Background

The Los Angeles County Department of Children and Family Services (department) is responsible for responding to allegations of child abuse and neglect (referrals)—it received more than 167,000 referrals in fiscal year 2017–18. The department receives referrals through its centralized hotline and routes them to one of its 19 regional offices for in-person investigation and case management, if applicable. The department’s budget and number of staff who provide services for children increased over four years, and the number of children receiving services has decreased.

Key Findings

• The department has allowed children to remain in unsafe and abusive situations for months longer than necessary because it did not start or complete investigations within required time frames.
  » It did not begin investigations within the required 24 hours or 10 days from receiving an allegation (depending on the severity of the referral) for 11 of the 30 cases we reviewed—in one case, it made one contact attempt within 24 hours but made no other attempts for 151 days when it ultimately removed children from an unsafe home situation.
  » It did not complete 21 of the 30 investigations we reviewed within the required 30 days after the in-person interview with the child—six exceeded 90 days and one was over 400 days.

• The department’s safety and risk assessments—used to decide a child’s immediate safety and need for services—have often been late and inaccurate making it difficult to mitigate risks to children’s safety.
  » It completed only 72 percent of safety assessments and 76 percent of risk assessments on time department wide during fiscal year 2017–18.
  » 25 of the 30 safety assessments we reviewed were not completed within 48 hours and one was completed over a hundred days late, and several did not accurately identify safety threats.
  » Supervisors did not approve all safety and risk assessments before the referrals were closed.

• The department did not consistently conduct the required home inspections and criminal background checks before placing children with relatives.

• Despite budget increases, more social workers, and reduced caseloads, the department did not always conduct monthly visits in the child’s home to assess the children’s well-being.

• Reunification assessments, which document caretakers’ behavioral problems and evaluate risk, were not completed timely in all but one of the cases we reviewed that required an assessment.

• Although it conducts robust reviews of circumstances surrounding the death of children in Los Angeles County, it does not track whether these reviews have resulted in meaningful, systemwide improvements.

Key Recommendations

The department should perform the following:

• Ensure it protects children by completing investigations, assessments, home inspections, and background checks in a timely manner by implementing a tracking process to identify and highlight when required activities are not completed on time.

• Revise policies and procedures and require annual training to staff and supervisors to ensure staff appropriately use assessments to identify safety threats and risks, and supervisors review their staff’s work within department set time frames.

• Strengthen and improve its quality control processes by broadening case reviews, evaluating the quality of supervisor reviews, and ensuring recommendations from child-death reviews are implemented.