

## Report in Brief

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Report No. A-09-16-01000

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
OFFICE OF INSPECTOR GENERAL



### Why OIG Did This Review

Congress has expressed concerns about the safety and well-being of children in foster care. These issues were highlighted in a media report that provided several examples of children who died while in foster care. Accompanying the deaths were allegations of negligence as a contributing factor and evidence of sexual and physical abuse, sometimes after clear warning signs.

Our objective was to determine whether the California Department of Social Services (Social Services), Community Care Licensing Division (licensing division), ensured that allegations and referrals of abuse and neglect of children eligible for foster care payments under Title IV-E of the Social Security Act, as amended (P.L. No. 74-271, Aug. 14, 1935), were recorded, investigated, and resolved in accordance with State requirements, as required by Federal law.

### How OIG Did This Review

From the 6,182 priority I, II, and III complaint investigations that the licensing division completed from July 1, 2013, through June 30, 2015, we judgmentally selected 100 complaints against group homes or certified foster family homes in which a child eligible for Title IV-E foster care payments was involved. We reviewed the case files for the 100 complaints and, when necessary, interviewed licensing program analysts and supervisors.

## California Did Not Always Ensure That Allegations and Referrals of Abuse and Neglect of Children Eligible for Title IV-E Foster Care Payments Were Properly Recorded, Investigated, and Resolved

### What OIG Found

The licensing division did not (1) accurately record or investigate one complaint, (2) complete investigations in a timely manner, (3) refer priority I and II complaints (the most serious) to the Investigations Branch, (4) adequately cross-report complaints to the Children and Family Services Division and to law enforcement, (5) conduct onsite inspections within 10 days, (6) associate an employee of a community care facility with the facility, and (7) adequately clear plan-of-correction deficiencies.

The licensing division (1) lacked policies and procedures or did not follow existing policies and procedures and (2) did not require its analysts and supervisors to take periodic mandatory complaint investigation training. As a result, licensed facilities may be out of compliance with licensing laws or regulations, and children's health and safety may continue to be placed at risk.

### What OIG Recommends and Social Services Comments

We recommend that the licensing division (1) develop an action plan to ensure that complaint investigations are completed in a timely manner; (2) develop additional policies and procedures as necessary and follow existing policies and procedures; (3) ensure that the new complaint system currently under development includes certain functionality; and (4) provide analysts and their supervisors periodic mandatory complaint investigation training to reinforce their knowledge of the laws, regulations, policies and procedures, and best practices related to complaint investigations.

Social Services agreed with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.