SOUTH CAROLINA GENERAL ASSEMBLY
Legislative Audit Council

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A REVIEW OF CHILD WELFARE SERVICES AT THE DEPARTMENT OF SOCIAL SERVICES

THROUGH ITS CHILD WELFARE SERVICES, DSS HAS THE GOAL OF PROTECTING CHILDREN FROM ABUSE AND NEGLECT. AGENCY STAFF ARE REQUIRED TO OPERATE IN A COMPLEX, HIGH-STRESS ENVIRONMENT, ACCOMPANIED BY POTENTIALLY SEVERE CONSEQUENCES FOR CHILDREN WHEN MISTAKES ARE MADE.

- DSS has not ensured that its workforce is well-qualified and compensated competitively when compared with similar positions in South Carolina and other states.
- South Carolina has child welfare caseloads that are excessive and inequitable from county to county.
- There is not an adequate system for screening, investigation, treatment, and placement of children in safe homes when abuse and neglect are reported.
- Data on child maltreatment deaths, particularly those with prior DSS involvement, is not reliable and should not be used as a measure of agency performance.
- Not all violent, unexpected, and unexplained child fatalities are being reported and reviewed as required by law.

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Legislative Audit Council

A Review of Child Welfare Services at the Department of Social Services

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Introduction and Background

Audit Objectives

Members of the General Assembly requested that the Legislative Audit Council review various issues pertaining to child welfare services, procurement, and agency management at the Department of Social Services (DSS). Through its child welfare services, the department investigates reports of child abuse and neglect and provides services to ensure the safety of the affected children. Our audit objectives were to:

- Document DSS expenditures and funding sources for child protective services and related programs.
- Determine whether the laws, regulations, policies, and practices for child protective services and related programs are effectively communicated and applied consistently.
- Assess whether the intake process for receiving reports of child abuse and neglect ensures that the reports are effectively addressed in compliance with state and federal law and policy.
- Determine whether DSS is effective and in compliance with state and federal law and policies when making out-of-home placements of children subjected to abuse and/or neglect.
- Review the effectiveness of South Carolina's systems for preventing and investigating child deaths resulting from abuse and/or neglect.
- Examine the reliability of data used by DSS in managing child protective services and related programs.
- Determine whether DSS can improve its policies and practices regarding the hiring of staff, training, caseloads, and allocation of staff.
- Review the use of outside contractors by DSS in the management of child protective services and related programs for the adequacy of the procurement methods and the effectiveness of the services provided.
- Evaluate whether the measures used by DSS to determine the success of child protective services and related programs are appropriate and used in an effective manner.

Scope and Methodology

The period of our review included primarily FY 08-09 through FY 12-13, with consideration of earlier and more recent periods when relevant. We reviewed employee qualifications, salaries, training, turnover, caseloads, abuse and neglect investigations, child deaths, alternative caregivers, family preservation, and data reliability.

Information used in this report was obtained from a variety of sources including:

- State laws and regulations.
- DSS policies, directives, guidelines.
- DSS contracts.
- Child fatality statistics.
- Human resource records.
- Interviews with DSS staff, county directors, other state agencies.
- DSS financial records.
- Child welfare case files.
- Practices in other states.
- Computer-generated data from the department's Child and Adult Protective Services System (CAPSS).
- Information from the Senate General Committee's DSS Oversight Subcommittee hearings held in 2014.

Criteria used to measure performance included federal and state laws and regulations, agency policy, agency contracts, practices in other states, and national standards. We also compared agency conditions with findings made by the Legislative Audit Council regarding DSS in 1985 and 2006.

We assessed internal controls in reviewing the department's child welfare data. We also reviewed the reliability of the department's data system and found limitations regarding the data, as described in this report.

This performance audit was conducted in accordance with generally accepted government auditing standards from 2007. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions, based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions, based on our audit objectives.

Overview of DSS Child Welfare Services

Child welfare services at DSS focus on protecting children under the age of 18 from abuse and neglect. Examples of these services include:

- Assessment of reported abuse and neglect to determine whether it is more likely than not to have occurred.
- Family preservation services, such as addiction counseling, home visitation, assessment of risk and safety, mental health counseling, and instruction in parenting skills.
- Foster care.
- Alternative care from relatives and other persons outside of foster care.
- Adoption services.

When a report of child abuse or neglect, as defined by state law, is received, DSS is required by state law to initiate an investigation within 24 hours. The department then has from 45 days to 60 days to determine whether the abuse or neglect was more likely than not to have occurred. When reports are received that are not child abuse or neglect, as defined by state law, they are not investigated.

When a child is found by a law enforcement officer or a court to be in "imminent and substantial danger," the child may be removed from her home and placed in foster care or with a relative or other person. The goal of DSS when a child is removed from her home is to reunite the child with her family or, if that goal cannot be achieved, to find another permanent home through adoption or other permanent situation.

Since FY 11-12, the department has referred medium- and lower-risk cases to a new program called Community Based Prevention Services (CBPS), in which private organizations provide case management, coordinating the provision of services to families not being investigated for abuse or neglect. Examples of these services, received on a voluntary basis by families, include addiction counseling, mental health counseling, and training in parenting skills.

For FY 12-13, DSS reported spending approximately $34.3 million on child protective services, $68.9 million on foster care, and $30 million on adoptions. Approximately 54% of these expenditures were made with federal funds. As of June 30, 2013, child welfare services in DSS consisted of 856 caseworkers and supervisors.

Trends in Child Abuse and Neglect and Services Provided by DSS

Reports of child abuse and neglect are made to DSS by medical professionals, school officials, neighbors, law enforcement, and other concerned parties.

Tables 1.1 and 1.2 summarize the abuse and neglect reports made from FY 08-09 through FY 12-13 by the number of families and the number of children. The numbers are sorted based on the type of DSS response.

Table 1.1: Abuse and Neglect Reports by Number of Families

DSS Response to Referrals	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13
Screened Out	9,893	9,912	10,347	8,698	4,734
Referred to Community Based Services*	-	-	-	3,052	10,640
Abuse/Neglect Investigations	17,621	18,801	17,764	15,740	11,921
TOTAL	27,514	28,713	28,111	27,490	27,295
Founded Investigations	6,812	6,952	6,843	6,831	5,794

* The Community Based Prevention Services Program was implemented statewide on June 1, 2012.

Source: DSS

Table 1.2: Abuse and Neglect Reports by Number of Children

DSS Response to Referrals	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13
Screened Out	18,610	19,061	20,080	16,694	9,160
Referred to Community Based Services*				6,720	23,198
Abuse/Neglect Investigations	37,534	40,378	38,120	34,037	25,281
TOTAL	56,144	59,439	58,200	57,451	57,639
Founded Investigations	12,358	11,832	11,372	11,682	10,186

* The Community Based Prevention Services Program was implemented statewide on June 1, 2012.

Source: DSS

Table 1.3 summarizes the number of child abuse and neglect investigations sorted by the age of the children.

Table 1.3: Abuse and Neglect Investigations by Number of Children and Age

AGE OF CHILDREN	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13
0 – 5	15,817	17,330	16,568	14,686	11,557
6 – 12	13,967	15,216	14,402	13,066	9,154
13 – 17	7,750	7,832	7,150	6,285	4,570
TOTAL	37,534	40,378	38,120	34,037	25,281

Source: DSS

Hiring and Training of Child Welfare Staff

We reviewed human resource management and related issues at the Department of Social Services and found areas in critical need of improvement without which the department will be less able to make significant progress in protecting children from abuse and neglect.

- There is no requirement that DSS caseworkers have college degrees in social work or a behavioral science.
- Caseworker salaries are not competitive with the salaries paid by other employers.
- DSS has unclear policies regarding training and certification for caseworkers after they have been hired. The department also has no central records that document whether caseworkers have been trained and certified.
- The department takes as long as nine months to hire and train a new child welfare caseworker.
- The caseloads managed by child welfare caseworkers are excessive, reducing the amount of attention that can be given to each child.
- DSS does not have a systematic process for allocating child welfare staff among its state, regional, and county offices.
- The department does not have a structured system for minimizing turnover among child welfare workers and county directors.

Qualifications to Become a Child Welfare Caseworker

DSS does not require its child welfare workers to have a degree in social work or a behavioral science, such as psychology. The department also requires no previous relevant experience. As a result, DSS child welfare workers may come to the job less prepared to work with victims of child abuse and neglect.

Minimum Qualifications in Other States

We reviewed the job qualifications for child welfare workers in South Carolina, North Carolina, Georgia, Alabama, and Tennessee, as well as other employers in South Carolina who hire social workers. In most cases, the minimum or preferred degree is a degree in social work or a behavioral science, although experience can sometimes compensate for the academic credential. Minimum requirements for employment in North Carolina counties, such as Burlington, Pitt, Catawba, and Mecklenburg, all include a social work degree. Mecklenburg County, which includes Charlotte, requires a minimum of a master's degree in social work if the candidate has no experience or a bachelor's degree in social work plus experience. Alabama specifically requires a social work degree.

Florida has enacted a law directing its child protective services agency to set a goal that by July 1, 2019, at least half of all child protection investigators and supervisors have a bachelor's degree or a master's degree in social work from a college or university social work program accredited by the Council on Social Work Education. Florida law does not require that those without degrees in social work be disqualified from consideration as child welfare workers.

Research on Caseworker Qualifications

We reviewed research to determine if there was evidence of demonstrable differences in performance between workers with a social work degree and those without. Examples from more than 30 years of research include:

- A 1987 Booz-Allen & Hamilton study of the Maryland Department of Social Services found that overall performance of workers with master's in social work (MSW) was significantly higher than for those who did not possess the MSW.
- A 1982 study based on data from the "1977 National Study of Social Services to Children and Their Families" found that workers with social work degrees were more effective in service delivery than workers with degrees in other fields.
- A 1990 study published in the journal *Social Work* confirmed that, overall, employees with social work degrees, either bachelor's or master's, were better prepared than were those without social work degrees. Researchers compared scores on state merit tests for family service workers, employees' quality assurance scores, ratings of employees from supervisors, measures of employees' commitment to social work values, and measures of employees' confidence in their educational preparedness.

- Authors of a 2007 study of child welfare workforce recruitment, selection, and retention in Maryland prepared by the University of Maryland School of Social Work in collaboration with the Maryland Department of Human Resources concluded that employees with a master's degree in social work were more likely than their colleagues without that degree to: perceive their supervisors as supportive, be included in decision-making, experience cooperation from peers, experience depersonalization about the work, and be more concerned about safety.

- We also found studies which showed having a social work or a behavioral science degree is linked to lower voluntary turnover rates.

In contrast, we found a 2006 study conducted by a professor at Florida A&M University which found no statistically significant difference in performance measures between workers who have the social work degree and those who did not.

Court Decrees

We identified six court decrees between 1995 and 2005 addressing the qualifications of applicants hired at child welfare agencies. For example, in Connecticut, hiring preference was required to be given to applicants with a bachelor's degree in social work or a human services field or a master's degree in social work. The U.S. District Court for the Eastern District of Michigan approved a decree mandating that Michigan entry-level caseworkers have a bachelor's degree in social work or a related human services field.

Recommendation

1. The Department of Social Services should require that newly-hired child welfare caseworkers have at least:

   - A bachelor's degree in social work; or
   - A bachelor's degree in a behavioral science; or
   - A bachelor's degree in another field with a minimum number of years of relevant experience.

No Periodic Review of Salaries

DSS has not periodically reviewed the salaries of staff to ensure that they are competitive, relative to comparable jobs in other government agencies and the private sector. Paying below-market wages can make it more difficult to recruit and retain qualified and experienced staff.

Caseworkers

In 2006, we reported that "the average minimum salary for child welfare workers was $29,797." In 2014 — eight years later — child welfare caseworkers start at $30,582. We also reported that South Carolina paid its entry-level caseworkers less than the average minimum salary of comparable workers in 42 states.

In our current review we compared the starting salary for child welfare caseworkers and county directors at DSS with the entry-level salaries of caseworkers and directors in other states and social workers in South Carolina doing other types of work. Tables 2.1 and 2.2 show the starting salaries as reported by each employer.

Table 2.1: Starting Salaries for Caseworkers

CASEWORKERS	SALARY
Medical University of South Carolina (MUSC) SOCIAL WORKER	$55,982
Richland School District 1** MASTER SOCIAL WORKER	$48,866
Mecklenburg County, NC SENIOR SOCIAL WORKER	$46,425
Guilford County, NC SOCIAL WORKER PROTECTIVE SERVICES	$45,513
Nash County, NC SOCIAL WORKER IA&T	$41,551
Orange County, NC CPS SOCIAL WORKER	$45,677
USC Center for Child and Family Studies TRAINING & DEVELOPMENT DIRECTOR	$40,524
Greenville County School District** SOCIAL WORKER	$38,076
Tennessee CASE MANAGER I	$31,968
South Carolina DSS CHILD WELFARE WORKER	$30,582
Georgia PROTECTION & PLACEMENT SPECIALIST*	$28,005

* Higher entry-level starting salaries are paid to persons with more advanced degrees or experience.
** School social workers are 9 – 10 month employees.

Source: LAC

Mecklenburg County, North Carolina includes Charlotte, North Carolina and can provide significant competition for caseworkers with adjacent York County.

In Tennessee, an applicant can be hired as a case manager 1 with a bachelor's degree and no experience, at a salary of $31,968. Once the employee successfully completes one probationary year, the employee is automatically promoted to case manager 2 with an annual salary of $36,276.

In Georgia, the new employees' academic credentials determine the starting salary. With a bachelor's degree in a behavioral science and no experience, the employee starts at $28,005. An employee with the same degree and one year experience can start at $30,869. With a bachelor's in social work, the employee starts at $32,412; and with a master's in social work, the annual starting salary is $34,039.

County Directors

We reviewed county directors' salaries for South Carolina, North Carolina, and Georgia. Directors in North Carolina counties manage comprehensive social services operations that may include children and family services; economic services; Medicaid; quality assurance; a fraud and integrity section; and research, planning, and evaluation.

In Georgia, county directors' salaries are based on total county population, the number of people living in poverty, and the total number of people younger than 19 years of age living in poverty. Directors' salaries for the largest, mid-size, and smallest counties in South Carolina, North Carolina, and Georgia are presented in Table 2.2.

Table 2.2: Salaries for County Directors

	Population	Salary
Large Counties Within the State		
Mecklenburg County, NC*	990,977	$158,000
Fulton County, GA**	984,293	$ 93,413
Greenville County, SC	471,266	$ 90,024
Charleston County, SC	372,803	$ 77,010
Mid-Size Counties Within the State		
Burke County, NC*	89,842	$ 76,932
Paulding County, GA**	146,950	$ 64,479
Lancaster County, SC	80,458	$ 64,196
Oconee County, SC	75,045	$ 56,100
Small Counties Within the State		
Hertford County, NC*	24,431	$ 75,012
Rabun County, GA**	16,235	$ 68,134
Calhoun County, SC	15,055	$ 56,100
Allendale County, SC	9,839	$ 51,000

* County offices deliver services such as economic, family and child protection, adult protection, Medicaid, research and planning, and fraud investigations.

** Georgia salaries are current as of 2013.

Sources: DSS, University of North Carolina, Chapel Hill School of Government, U.S. Census Bureau 2013 estimated population, and Georgia Department of Audit and Accounts

Career Path

DSS has not had a career path for child welfare caseworkers who want to advance within the agency while continuing to work in child protective services. According to DSS:

> Since February 2013, we started a new career path for child protective services (CPS) line workers. We established a new position description called 'Performance Coach' with the intention of reclassifying and promoting certain accomplished CPS line workers to help other CPS line workers in their areas of expertise to improve performance through the Performance Coach's mentorship. Additionally, we are in the process of creating a structured career path to advance employees through their current band or to other classifications.

As of July 2014, DSS was still in the process of developing this career path.

Recommendations

2. The Department of Social Services should, on a recurring basis, undertake a comprehensive comparison of annual salaries paid to child welfare staff employed by other government and non-governmental agencies throughout South Carolina and neighboring states.

3. The Department of Social Services should use the results of a recurring compensation review to make adjustments to ensure that child welfare staff are compensated at levels commensurate with their qualifications and responsibilities.

4. The Department of Social Services should develop a career path with increasing salaries for experienced child welfare staff.

Improvements Needed in Training and Certification Process

DSS has unclear training and certification policies for its caseworkers and supervisors. In addition, the department has not maintained central records regarding who has been trained and certified. As a result, there is reduced assurance that caseworkers and supervisors are adequately trained to protect children from abuse and neglect.

We first examined this issue almost 30 years ago. In a 1985 review of DSS, we found that only screening and assessment workers were required to be certified. In addition, we found that the department did not maintain adequate central records of caseworker training and certification.

Overview of Current Training Program

Training for new caseworkers is provided by the University of South Carolina (USC). Included in the training are 19 days of classroom instruction provided by the university's School of Social Work and 6 weeks of assignments completed by caseworkers in their home counties. This portion of the certification training is known as Child Welfare Basic. New caseworkers are required to pass a test on the material presented in Child Welfare Basic. Also, the university's Children's Law Center conducts three days of legal training. Finally, caseworkers are required to have 10 additional hours of child welfare training within 12 months of hire, prior to becoming certified. DSS policy limits new caseworkers to a small number of family preservation cases under close supervision until they become certified.

According to a September 14, 2004, DSS memorandum, caseworkers must receive 20 hours of continuing education each year. Continuing education is provided by multiple entities, including DSS and USC. Forty-five hours of leadership training are provided by USC for caseworkers transitioning to supervisory roles. DSS also has a contract with a private company to provide training, guidance, and support services for caseworkers.

Unclear Training Policy

DSS policy 701 requires that caseworkers who screen and assess reports of child abuse and neglect be certified. Other categories of caseworkers are not addressed in this policy.

DSS officials report that the department has an unofficial requirement that all caseworkers be certified, including caseworkers working with screening, assessment, family preservation, foster care, and adoption. In August 2014, DSS issued a directive memo stating that all caseworkers are required to be certified. However, this requirement is not listed in DSS's training policy.

No Central Training and Certification Records

DSS does not maintain central records of the training and certification received by caseworkers, nor does it maintain central records of continuing education. Thus, there is an increased likelihood that caseworkers are not consistently meeting agency requirements.

We surveyed several county directors to determine if their offices had documentation of caseworker and supervisor certification. The directors indicated that they receive email notification when a new caseworker passes the Child Welfare Basic exam requirement for certification, but received no other notification. The counties also did not maintain a listing of certified caseworkers.

Other Training Issues

During our review, several county directors stated that DSS did not consistently provide county staff with training before the state office implemented a new policy or program, increasing the likelihood that counties will misunderstand or not adhere to agency requirements.

Recommendations

5. The Department of Social Services should make clear in its written policies which caseworkers are required to be certified.

6. The Department of Social Services should maintain central records documenting whether caseworkers have complied with the department's training and certification requirements.

7. The Department of Social Services should ensure that staff are trained on new agency policies and programs before they are implemented.

Turnover Among Caseworkers and County Directors

We reviewed turnover among child welfare workers and county directors and found that:

- DSS has not analyzed turnover and has no standard for determining whether its turnover rate is within acceptable limits.

- Neither DSS nor the state human resource agency collects complete data on employee turnover.

A 2006 federal General Accountability Office (GAO) report ranked caseworker recruitment and retention among the top three challenges facing child welfare agencies working to improve outcomes for children. Turnover lowers morale, reduces efficiency, and consumes time as the agency recruits, hires, and trains new workers.

Without complete data, the ability of DSS to address employee turnover is diminished.

DSS has not Analyzed Turnover

DSS reported that it has not conducted a formal trend analysis regarding staff turnover in the agency. According to DSS, the agency relies on turnover data from the state government information system. The state information system does not indicate who is and who is not a child welfare worker for purposes of doing an analysis exclusively of child welfare workers. Most child welfare workers are classified as Human Services Specialist II. However, included in that classification are DSS staff who do not work with child welfare cases.

In addition, the state government information system used by DSS includes turnover data only for employees who leave state government. The data does not include employees who take another position in the same agency or in another state agency. To measure annual turnover requires that the agency know the number of employees who left the job for any reason.

State government information system staff and the division of human resources within the State Budget and Control Board are collaborating on developing a report that will capture employee movement between state agencies that use the state government information system. This report is expected to become available by March 2015.

LAC Analysis of DSS Turnover Rates

We reviewed data on DSS child welfare employees from calendar years 2011, 2012, and 2013. This data includes employees in jobs classified as GA40, Human Services Specialist II, excluding DSS employees in this classification working in economic services, adult protection, or foster care licensing. We included child welfare workers who left their jobs to work elsewhere in DSS or in state government as well as employees who left state government. Our findings appear in Table 2.3. We found that among child welfare workers in child protective services and foster care, the turnover rate has increased more than 12 percentage points from 2011 to 2013.

Table 2.3: Child Welfare Caseworker Turnover Rates

Calendar Year	Average No. of Employees	Number of Employees Leaving the Job	Turnover Rate
2011	627.5	101	16.1%
2012	603.5	140	23.2%
2013	577.0	166	28.8%
3-Year Data	621.5	407	65.5%

Data represents employees with a GA40 classification, which does not include supervisors.

Sources: DSS and LAC

We also reviewed county director turnover rates as shown in Table 2.4. DSS reported this data by calendar year. From 2011 through August 2014, 27 county directors left their positions. The number of county directors who left the job for any reason is reported in Table 2.4.

Nine of the directors retired, five were demoted, three resigned, one was reassigned, three were promoted, four took other jobs at DSS, and two were dismissed.

Table 2.4: Number of Directors Who Left the Job from 2011 Through August 2014

YEAR	DIRECTORS WHO LEFT THE JOB
2011	7 (15.2%)
2012	9 (19.6%)
2013	7 (15.2%)
2014*	4 (8.7%)
4-Year Data	27 (58.7%)

* As of August 2014

Source: DSS

No Turnover Rate Standard

DSS has no standard against which to compare turnover rates among its child welfare staff. The department also has not conducted a formal analysis of turnover trends. As a result, the department's ability to identify and respond to turnover problems is diminished.

Inaccurate Child Welfare Employee Turnover Data

DSS reported inaccurate turnover rates among child welfare workers in the agency's final report on the federal fiscal year 2010-2014 child and family services plan to the Administration for Children and Families of the federal Department of Health and Human Services.

In reporting child welfare turnover, DSS improperly included employees working in economic services and adult protective services, functional areas that are not child welfare. Data reported by DSS, along with corrected figures calculated by the LAC, appear below in Table 2.5.

Child welfare workers include those working in child protective services, foster care, intensive foster care and clinical services, and adoption services. Child welfare workers are primarily classified as GA40, Human Services Specialist II. However, that classification also includes workers in other jobs such as economic services. We reviewed complete lists of DSS employees, full-time and temporary. Our lists included all employees on the payroll in January and December in 2011, 2012, and 2013. Numbers of child welfare workers remaining after removing non-child welfare caseworkers are found in Table 2.5.

Table 2.5: Number of Child Welfare Caseworkers

Data Reported by DSS		Data Calculated by LAC	
Fiscal Year	GA40 Employees**	Calendar Year	GA40 Employees**
11-12	1,227.50	2011	627.5
12-13	1,179.50	2012	603.5
13-14*	1,178.00	2013	577.0

* July through December 2013
** Data represents employees with a GA40 classification, which does not include supervisors.

Source: DSS

In addition, in calculating its turnover rate, DSS only included those workers who left state government. Its calculation does not include workers who left a job in child welfare for another position at DSS or another state agency. As a result, the information provided by DSS gives a false impression of the number of full-time child welfare workers on staff, while undercounting the number of workers who actually leave a job in child welfare. In the absence of accurate information on turnover, the agency is unable to diagnose its problems in this area. Those who rely on this information for reporting or funding purposes, but who are unfamiliar with the methodology by which this calculation was derived, are left with a false impression of the size of the child welfare staff and the magnitude of its child welfare staff turnover.

Reasons for Leaving the Job

When employees leave a job, DSS collects data on the reason for the departure. However, the information might not be useful in determining why people leave. For most employees, the explanation for leaving the job is listed as "personal." In the absence of any other explanation, this is insufficient for determining why people resign and whether there is something that discourages workers from staying on the job. Reasons for separation for all child welfare workers for whom data was available are shown in Table 2.6.

Measuring the reasons why employees leave is problematic because employees are not always willing to share their true reasons for leaving. However, in addition to in-person exit interviews, employees might be given other options of responding, such as responding anonymously to questions available online.

Table 2.6: Reasons Reported for Leaving Child Welfare Positions

REASON	2010	2011	2012	2013	2014	TOTAL
Personal	20	82	108	131	54	395
Other Employment	6	14	15	20	3	58
Retirement	3	13	21	12	8	57
Dismissal	0	8	17	19	12	56
Other	0	6	8	6	8	28
Deceased	1	2	0	1	0	4

Source: DSS

Recommendations

8. The Department of Social Services should conduct periodic analyses of turnover rates among child welfare staff.

9. The Department of Social Services should establish annual goals against which to compare annual turnover rates for child welfare employees and county directors.

10. The State Budget and Control Board should report turnover rates comprised of all employees who leave their jobs, including employees who move to other jobs within the same agency or accept jobs with other South Carolina state agencies.

11. The Department of Social Services should refine its system for determining why employees leave the agency so that the agency has a clear understanding of why employees leave and can take appropriate steps to minimize turnover.

12. When analyzing or reporting turnover rates among child welfare staff, the Department of Social Services should include in the analysis only staff who perform child welfare work.

Excessive Time to Replace Child Welfare Caseworkers

The DSS state office does not routinely analyze the time it takes to replace child welfare caseworkers or to train their replacements. In an LAC survey of six county offices, directors provided data documenting that the average period of time, in 2013 and 2014, for hiring new caseworkers was 4.4 months, with another 4.5 months for the caseworkers to become certified. On average, it took almost nine months to hire and train new caseworkers.

An excessive period of time for replacing caseworkers and training their replacements can increase the caseloads of remaining workers and reduce the quality of services they provide. An excessive replacement period may also increase the chance of subsequent resignations due to the greater burden on staff caused by the prior resignations.

According to DSS officials, the department has recognized these issues and is offering continuous postings for vacant positions, has started a pilot program to reduce the amount of training newly hired employees must complete, and has begun group interviews in larger counties.

Recommendations

13. The Department of Social Services should analyze its processes for ways to reduce the amount of time it takes to hire and train new caseworkers without reducing the quality of the workers or their training.

14. The Department of Social Services should reduce the amount of time it takes to hire and train new caseworkers without reducing the quality of the workers or their training.

Caseload Management and Staff Allocation

In 1985 and 2006, the Legislative Audit Council reported that the Department of Social Services did not have:

- Maximum caseload standards for its child welfare caseworkers.
- Formal methodology for calculating caseloads.
- Policy that requires caseloads be approximately equal from county to county.

In our current review, we found the same issues.

As a result, DSS caseloads are often excessive, reducing the ability of caseworkers to investigate and prevent child abuse and neglect.
In June 2014, the department developed maximum caseload standards.

No Caseload Standards

DSS did not have standards for the maximum number of families or children assigned to each child welfare caseworker until June 2014, when it submitted caseload standards to the federal Administration for Children and Families. Maximum caseloads included 24 children for assessment caseworkers, 24 children for treatment caseworkers, and 20 children for foster care caseworkers.

Because other states report maximum caseload standards for assessment and treatment caseworkers in terms of families, we converted the DSS standards that were based on children to standards based on families, assuming an average of 2.25 children per family.

In Table 3.1, DSS standards are compared with standards developed by the Child Welfare League of America (CWLA), the state of Alabama, and Mecklenburg County, North Carolina.

The department reports that, due to limited resources, it has not implemented these standards.

Table 3.1: Minimum Caseload Standards for Child Welfare Caseworkers

	ASSESSMENT (FAMILIES)	TREATMENT (FAMILIES)	FOSTER CARE (CHILDREN)
South Carolina DSS	11 (24 children)	11 (24 children)	20
Child Welfare League of America	12	17	15
Alabama	12	12	18
Mecklenburg County, North Carolina	10	10	15

Sources: DSS, CWLA, Alabama, and Mecklenburg County, North Carolina

Recommendation

15. The Department of Social Services should implement maximum caseload standards for its child welfare caseworkers.

No Methodology for Calculating Caseloads

According to DSS management, DSS did not have a formal, written methodology for calculating its child welfare caseloads. In addition, state law does not require DSS to have a formal written methodology for calculating caseloads. Without a formal, written methodology, there is reduced assurance that caseloads will be calculated consistently from location to location and across time.

Recommendations

16. The Department of Social Services should develop and implement a written methodology for calculating child welfare caseloads.

17. The General Assembly should amend state law requiring that the Department of Social Services develop and implement a written methodology for calculating child welfare caseloads.

Excessive and Inequitable County Caseloads

We found that South Carolina has child welfare caseloads that are excessive and inequitable from county to county.

DSS produced a May 21, 2014 listing of each child welfare caseworker in the state and the number of cases each had in the areas of assessment, family preservation, and foster care. We compared the combined caseloads of each caseworker with the standards developed by the Child Welfare League of America and the standards developed by DSS in June 2014.

Excessive Caseloads

As shown in Table 3.2, a total of 52.7% of 611 county caseworkers statewide had combined caseloads that exceeded CWLA standards. 27.3% of caseworkers had caseloads that exceeded the standards by 50% or more, 8.8% of caseworkers had caseloads that exceeded the standards by 100% or more, and 1.8% of caseworkers had caseloads that exceeded the standards by 150% or more.

We also found that 57.8% of the 611 county caseworkers statewide had combined caseloads that exceeded DSS standards. 38.5% of the caseworkers had caseloads that exceeded the standards by 50% or more, 21.9% of caseworkers had caseloads that exceeded the standards by 100% or more, and 11.3% of caseworkers had caseloads that exceeded the standards by 150% or more.

Statewide, 19.3% of caseworkers were assigned more than 50 children, 11.3% were assigned more than 60 children, and 2.8 % were assigned more than 75 children.

Inequitable Caseloads Between Counties

Neither DSS nor state law require that caseloads for the department's child welfare caseworkers be approximately equal from county to county.

Among the counties with populations exceeding 100,000, the percentage of caseworkers whose combined caseloads exceeded CWLA standards ranged from 40.0% in Dorchester to 85.7% in Aiken County. The percentage exceeding DSS standards ranged from 45.5% in Beaufort County to 92.9% in Aiken County.

Among the counties with populations under 30,000, the percentage of caseworkers whose combined caseloads exceeded CWLA standards ranged from 0.0% in Union, Abbeville, Fairfield, Saluda, Bamberg, Calhoun, Allendale, and McCormick Counties to 66.7% in Hampton County. The percentage exceeding DSS standards ranged from 0% in Abbeville, Bamberg, Allendale, and McCormick Counties to 66.7% in Hampton County.

Revenue limitations and competing expenditure objectives can prevent a child welfare agency from staying within its maximum caseload standards. With or without adequate resources, approximately equal caseloads from county to county will help ensure that services are provided in an equitable manner across the state.

Recommendations

18. The Department of Social Services should ensure that child welfare caseloads are approximately equal from county to county.

19. The General Assembly should amend state law requiring that the Department of Social Services ensure that child welfare caseloads are approximately equal from county to county.

Table 3.2: Percentage of Caseworkers and Supervisors Whose Combined Caseloads on 5-21-14 Exceeded CWLA and DSS Standards

County By Descending Order of Population	# Caseworkers	CWLA Standards				DSS Standards				2010 Census Population
		Exceeded	Exceeded by 50% or More	Exceeded By 100% or More	Exceeded by 150% or More	Exceeded	Exceeded by 50% or More	Exceeded By 100% or More	Exceeded by 150% or More	
Greenville	52	61.50%	26.90%	3.80%	0.00%	65.40%	46.20%	23.10%	7.70%	451,225
Richland	48	54.20%	39.60%	8.30%	2.10%	54.20%	35.40%	20.80%	14.60%	384,504
Charleston	44	68.20%	50.00%	13.60%	2.30%	72.70%	52.30%	43.20%	27.30%	350,209
Spartanburg	32	65.60%	53.10%	34.40%	9.40%	71.90%	65.60%	46.90%	25.00%	284,307
Horry	19	47.40%	31.60%	0.00%	0.00%	57.90%	21.10%	10.50%	5.30%	269,291
Lexington	29	58.60%	51.70%	44.80%	13.80%	55.20%	55.20%	44.80%	37.90%	262,391
York	26	61.50%	42.30%	15.40%	0.00%	61.50%	50.00%	38.50%	19.20%	226,073
Anderson	31	64.50%	16.10%	6.50%	0.00%	61.30%	35.50%	9.70%	3.20%	187,126
Berkeley	29	44.80%	17.20%	0.00%	0.00%	48.30%	37.90%	6.90%	0.00%	177,843
Beaufort	11	45.50%	18.20%	9.10%	0.00%	45.50%	27.30%	18.20%	18.20%	162,233
Aiken	14	85.70%	14.30%	0.00%	0.00%	92.90%	57.10%	28.60%	7.10%	160,099
Florence	12	50.00%	41.70%	33.30%	0.00%	50.00%	41.70%	41.70%	25.00%	136,885
Dorchester	15	40.00%	20.00%	0.00%	0.00%	66.70%	26.70%	0.00%	0.00%	136,555
Pickens	22	81.80%	31.80%	4.50%	4.50%	72.70%	36.40%	27.30%	9.10%	119,224
Sumter	12	83.30%	16.70%	0.00%	0.00%	83.30%	83.30%	50.00%	8.30%	107,456
Orangeburg	13	15.40%	0.00%	0.00%	0.00%	38.50%	7.70%	0.00%	0.00%	92,501
Lancaster	12	58.30%	16.70%	0.00%	0.00%	66.70%	33.30%	16.70%	0.00%	76,652
Oconee	15	66.70%	20.00%	6.70%	0.00%	60.00%	46.70%	20.00%	6.70%	74,273
Greenwood	5	40.00%	0.00%	0.00%	0.00%	40.00%	20.00%	0.00%	0.00%	69,661
Darlington	12	75.00%	16.70%	0.00%	0.00%	75.00%	33.30%	8.30%	0.00%	68,681
Laurens	9	44.40%	33.30%	22.20%	11.10%	66.70%	44.40%	11.10%	0.00%	66,537
Kershaw	9	66.70%	33.30%	0.00%	0.00%	77.80%	55.60%	11.10%	0.00%	61,697
Georgetown	6	33.30%	0.00%	0.00%	0.00%	33.30%	33.30%	0.00%	0.00%	60,158
Cherokee	11	72.70%	63.60%	18.20%	0.00%	72.70%	45.50%	36.40%	36.40%	55,342

County By Descending Order of Population	# Caseworkers	CWLA Standards				DSS Standards				2010 Census Population
		Exceeded	Exceeded by 50% or More	Exceeded By 100% or More	Exceeded by 150% or More	Exceeded	Exceeded by 50% or More	Exceeded By 100% or More	Exceeded by 150% or More	
Chesterfield	8	50.00%	25.00%	0.00%	0.00%	50.00%	12.50%	0.00%	0.00%	46,734
Colleton	8	87.50%	37.50%	0.00%	0.00%	87.50%	50.00%	50.00%	37.50%	38,892
Newberry	5	80.00%	80.00%	0.00%	0.00%	80.00%	80.00%	40.00%	0.00%	37,508
Clarendon	5	0.00%	0.00%	0.00%	0.00%	40.00%	0.00%	0.00%	0.00%	34,971
Williamsburg	5	20.00%	0.00%	0.00%	0.00%	60.00%	20.00%	0.00%	0.00%	34,423
Chester	7	14.30%	0.00%	0.00%	0.00%	14.30%	14.30%	14.30%	0.00%	33,140
Marion	9	11.10%	0.00%	0.00%	0.00%	33.30%	11.10%	.0.00	0.00%	33,062
Dillon	9	44.40%	11.10%	0.00%	0.00%	55.60%	44.40%	22.20%	11.10%	32,062
Union	11	0.00%	0.00%	0.00%	0.00%	18.20%	0.00%	0.00%	0.00%	28,961
Marlboro	8	25.00%	12.50%	12.50%	0.00%	37.50%	25.00%	12.50%	12.50%	28,933
Edgefield	6	16.70%	0.00%	0.00%	0.00%	16.70%	16.70%	0.00%	0.00%	26,985
Abbeville	3	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	25,417
Jasper	5	20.00%	0.00%	0.00%	0.00%	20.00%	20.00%	0.00%	0.00%	24,777
Fairfield	5	0.00%	0.00%	0.00%	0.00%	40.00%	0.00%	0.00%	0.00%	23,956
Barnwell	5	20.00%	0.00%	0.00%	0.00%	40.00%	20.00%	0.00%	0.00%	22,621
Hampton	3	66.70%	33.30%	0.00%	0.00%	66.70%	66.70%	66.70%	33.30%	21,090
Saluda	3	0.00%	0.00%	0.00%	0.00%	33.30%	0.00%	0.00%	0.00%	19,875
Lee	5	40.00%	0.00%	0.00%	0.00%	40.00%	20.00%	20.00%	0.00%	19,220
Bamberg	4	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15,987
Calhoun	4	0.00%	0.00%	0.00%	0.00%	25.00%	0.00%	0.00%	0.00%	15,175
Allendale	3	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10,419
McCormick	2	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10,233
STATEWIDE	**611**	**52.70%**	**27.30%**	**8.80%**	**1.80%**	**57.80%**	**38.50%**	**21.90%**	**11.30%**	**4,625,364**

The combined caseloads for each caseworker include assessment, treatment, and foster care services.

Source: LAC based on DSS data.

Staff Allocation to State, Regional, and County Offices

DSS has no systematic methodology for allocating staff to state, regional, and county offices.

We first recommended that DSS develop a methodology for allocating staff in 1985 and again in 2006. DSS officials stated that staffing decisions are a product of management discretion, after considering available resources and needs throughout the organization.

In the absence of a systematic methodology for allocating staff:

- DSS will be less able to allocate resources to protect abused and neglected children.
- The agency risks finding itself reacting to crises and having to reallocate staff from other parts of the agency, thereby leaving those areas understaffed.
- The validity of the agency's approach to allocating staff cannot be independently verified.

In the Spring of 2014, DSS temporarily reallocated 66 staff to Richland County DSS from the central office, 5 regional offices, and 15 county offices: Anderson, Bamberg, Beaufort, Berkeley, Clarendon, Darlington, Florence, Greenville, Georgetown, Horry, Lee, Lexington, Marion, Oconee, and Orangeburg. The assignments required 54 of the workers to dedicate a portion of their workweeks to Richland County, while continuing to perform their regularly, assigned duties.

Recommendation

20. The Department of Social Services should establish and implement a formal methodology for allocating all staff, including child welfare staff, among its state, regional, and county offices.

Child Fatalities

We found that child fatality data reported to the General Assembly and the public regarding child maltreatment deaths, particularly those with prior DSS involvement, is not reliable and should not be used as a measure of agency performance. Changes to the system of reviewing child fatalities could result in improved analysis of deaths and help reduce the number of preventable deaths.

We also found 152 child fatalities that occurred between 2009 and 2013 for which the State Law Enforcement Division does not have a report from the state's county coroners, but which appeared to meet the criteria set forth in law that would require the fatalities to be reported. In 104 cases, it appears the child deaths were not reported by the coroners as required by state law, while in 48 cases, there is evidence to indicate that the fatalities were reported by the coroners. SLED, however, did not have these fatalities in its database. Without this information, the State Child Fatality Advisory Committee will be less able to fulfill its mission to decrease the incidences of preventable child deaths.

Underreporting of Child Maltreatment Deaths Nationwide

Based on information provided by 49 states to the National Child Abuse and Neglect Data System (NCANDS), the federal Department of Health and Human Services estimates approximately 1,640 children died from abuse and neglect in FYY 2012. However, a number of studies have reported that the number of child maltreatment deaths may be significantly underreported.

A July 2011 report by the U.S. Government Accountability Office found that national data likely underestimate the number of children who died from maltreatment. A study in Michigan conducted in 2000 and 2001 to identify neglect-related deaths among children less than 10 years old documented a 75% increase in its estimate of fatal child maltreatment deaths, from 110 to 192 over a two-year period. A 2013 article in the Child Welfare Journal suggested that, due to the limitations of child welfare and other mortality data to accurately count fatal child maltreatment, the true magnitude of fatal child maltreatment is currently unknown. The Casey Family Programs foundation stated in a presentation in 2013 that NCANDS data regarding maltreatment fatalities is an undercount, possibly a large undercount.

Among the reasons cited by child welfare organizations for the undercount is the possible improper classification of many maltreatment deaths as unintentional injury deaths. A report on national child abuse and neglect deaths in the United States by the Every Child Matters Education Fund states studies have found that approximately 50% of deaths reported as "unintentional injury deaths" are later reclassified after further investigation by medical and forensic experts as deaths due to maltreatment, primarily as a result of inadequate supervision rising to the level of neglect.

It also is often more difficult to establish whether a fatality was caused by neglect than it is to establish a physical abuse fatality. The different agencies that come into contact with a case of a possible child neglect fatality may have differing definitions of what constitutes neglect, and these definitions may be influenced by the laws, regulations, and standards of each agency. Other reasons cited include difficulties identifying, investigating, and reporting deaths to child protective services, lack of standard definitions of child maltreatment, and differing legal standards for substantiation of maltreatment.

DSS Data on Child Fatalities Reported to the General Assembly

The data reported by DSS is not a reliable measure of child maltreatment deaths with prior DSS involvement and is not a valid metric for measuring agency performance. The DSS data is not the result of an exhaustive search for maltreatment deaths and includes deaths other than maltreatment deaths. The data includes child fatalities that had been reported to SLED by county coroners as being violent, unexpected, or unexplained. It also includes additional deaths DSS discovered through other means, including media reports and reports from DSS county offices. These child fatalities are mostly natural deaths that are not violent, unexpected, or unexplained. It is unclear why this data was included. These are also only a small portion of all child fatalities.

In March 2014, DSS reported to the Senate General DSS Oversight Subcommittee that, between 2009 and 2013, there had been significant declines in child fatalities with prior DSS involvement between 2010 and 2011 and between 2012 and 2013. DSS further stated that there had not been an increase in child deaths with prior DSS involvement since February 2011.

Prior involvement is defined as:

> Cases where DSS child welfare was involved with the deceased child prior to death or with a sibling, half-sibling, or step-sibling of the child, no matter what the cause of death, the correlation of the previous DSS involvement to the death, or the time elapsed since the prior DSS involvement.

Table 4.1 shows the number of deaths with prior DSS involvement reported by DSS to the committee.

Table 4.1: DSS Data on Child Fatalities with DSS Involvement

	2009	2010	2011	2012	2013
Cases with Prior DSS Involvement	96	101	88	87	76
% Change from Previous Year		5.2%	(12.9%)	(1.1%)	(12.6%)

Source: DSS

Table 4.2 shows the total number of resident child fatalities the Department of Health and Environmental Control (DHEC) provided to the LAC, the number where SLED had opened a case based on a coroner's report, and the number that DSS used when developing its figures.

Table 4.2: Child Fatalities as Reported by DHEC, DSS, and SLED

AGENCY	2009	2010	2011	2012	2013
DHEC Total Child Deaths	717	687	665	651	614*
DSS Total Deaths Reported to SLED and Additional Reports	261	244	217	193	191
SLED Total Violent, Unexpected, or Unexplained Deaths	214	183	172	156	161

* 2013 data is provisional.

Sources: DHEC, DSS, and SLED

It is not possible from this analysis to conclude that deaths with DSS involvement have declined. In order for this analysis to be more accurate, DSS should have reviewed all child deaths.

State Child Fatality Advisory Committee Data on Child Fatalities

We also reviewed and analyzed data reported by the State Child Fatality Advisory Committee (SCFAC). The SCFAC's review focused on child deaths that had been reported to SLED by county coroners as being violent, unexpected, or unexplained. These cases were then reviewed for prior DSS involvement. This analysis did not show any decline in cases with DSS involvement between 2011 and 2013.

Table 4.3: Child Fatalities Reported to SLED and Those with Prior DSS Involvement

CHILD FATALITIES	2009	2010	2011	2012	2013
Reported to SLED	215*	183	173**	156	160
Reported to SLED with Prior DSS Involvement	74	76	60	62	62

* One case included two child fatalities.
** A 2011 fatality was reported in 2013.

Sources: SLED and LAC Analysis

This analysis does not contain an accurate measure of cases with prior DSS involvement, nor does it contain an accurate measure of child deaths which resulted from maltreatment. These numbers include deaths where the manner of death is listed as accidental or natural. For example, in 31 (52%) of the 60 cases with DSS involvement from 2011, the manner of death is listed as either accidental or natural. While child maltreatment deaths are sometimes classified as accidental or natural deaths, it is likely that a substantial number of the deaths with prior DSS involvement resulted from circumstances in which it is questionable whether DSS could have intervened to prevent the fatality.

In addition, we found 152 unexpected, unexplained, or violent deaths that had been not been reported to SLED or which SLED did not have in its database (see p. 36).

Data on Child Fatalities Reported to the Federal Government by DSS

Table 4.4 summarizes data reported by DSS to the National Child Abuse and Neglect Data System (NCANDS). This data is reported yearly in the Child Maltreatment report published by the U.S. Department of Health and Human Services. The deaths reported are only those that have been determined to be the result of child maltreatment. Data in the report is listed by date of determination that the death resulted from maltreatment rather than the actual date of death. We reviewed the list of fatalities reported to NCANDS, adjusted for the year of death, and then determined if these cases had any prior DSS involvement.

Table 4.4: Child Maltreatment Fatalities Reported by DSS to NCANDS

CHILD MALTREATMENT FATALITIES	2009	2010	2011	2012	2013
Reported to NCANDS	30	25	17	16	17
Reported to NCANDS with Prior DSS Involvement	15	13	9	9	8

Source: DSS

While this data is perhaps the best measure of child maltreatment deaths and those that had prior DSS involvement, the number of child maltreatment deaths may be underreported. To improve estimates of child fatality figures, states are increasingly consulting other data sources for deaths attributed to child maltreatment. A number of studies, including some funded by the Centers for Disease Control and Prevention, have suggested that more accurate counts of maltreatment deaths are obtained by linking multiple reporting sources, including death certificates, crime reports, child protective services reports, and child death review records. The 2011 federal Child and Family Services Improvement and Innovation Act requires states to describe the sources of information used to compile their statistics on child maltreatment deaths. Also, if these statistics do not include deaths from the state's vital statistics department, law enforcement agencies, child death review teams, or coroners or medical examiners, the agency is to explain why.

In its 2013 NCANDS commentary, DSS stated that coroners, medical examiners, law enforcement, and DHEC report all child deaths, which were not the result of natural causes, to SLED for an investigation. The children whose deaths appear to have been a result of child maltreatment are reported to DSS by SLED following its investigations. This list is compared to DSS data to ensure child maltreatment deaths are reported accurately and are not duplicated.

During our review, we found that South Carolina's statistics do not include deaths from DHEC's Office of Public Health Statistics and Information Services or from the Department of Public Safety. Using data from multiple sources, we identified 152 child fatalities between 2009 and 2013 that were either not reported or not entered into SLED's database.

In addition, SCFAC, which reviews child fatalities in order to help decrease the incidence of preventable child deaths, excludes from its review motor vehicle deaths that are investigated by the Department of Public Safety. During our review, we identified nine child fatalities that occurred between 2010 and July 2014 where a child was a passenger in a vehicle driven by a parent under the influence of drugs or alcohol.

During our review, DSS stated that it will identify a contact with the Department of Public Safety to identify any children who were found to have died as a result of abuse or neglect and include them in future NCANDS reports. DSS also stated that it will update future NCANDS reports to include the exact contributors of the information on child fatalities due to abuse or neglect.

Child Death Reporting in Other States

In South Carolina, the SCFAC reviews child fatalities in order to develop an understanding of the deaths, develop plans for implementing changes within the agencies represented, and advise the Governor and General Assembly on statutory, policy, and practice changes. The most recent SCFAC report makes recommendations using the five manners of death categories (homicide, suicide, accidental, natural, and undetermined). However, SCFAC does not report specifically on the number of child fatalities that are the result of maltreatment or the number of maltreatment deaths with prior DSS involvement. According to SCFAC staff, future reports will include data on cases with prior DSS involvement and, also, data on the incidence of child fatality due to maltreatment.

We found that other states do report the number of maltreatment deaths and those with prior DSS involvement. In Georgia, state law requires an annual report on child fatalities in the state. The law requires that the report include, "Whether the children were known to any state or local agency." For 2012, Georgia reported that there were 48 child fatalities with a reported history of child maltreatment and 35 fatalities with an open case at the time of death. Indiana's Department of Child Services (DCS) issues yearly reports that include the number of child maltreatment deaths and also those which had prior history with DCS. The data is used, in part, to evaluate, review, and modify DCS policy, practice, and procedure, where warranted.

The Arizona Child Fatality Review Program also reports statistics on the number of maltreatment deaths and those with prior child protective services (CPS) involvement. In 2011, Arizona's program found 71 maltreatment deaths, of which 34 had prior CPS involvement, including 15 which had open cases at the time of death. The Office of the Inspector General in the Illinois Department of Children and Family Services investigates child fatalities which had prior department involvement and issues a yearly report to the Governor and General Assembly. Virginia's DSS publishes a similar report.

In addition, the National Center for the Review and Prevention of Child Deaths has developed a child death review (CDR) case reporting system. The system is used in 43 states, but not in South Carolina. A form is used to collect comprehensive information from multiple agencies participating in a child death review. The form documents the circumstances involved in the death, investigative actions, services provided or needed, key risk factors, and actions recommended and/or taken by the CDR team to prevent other deaths.

Recommendations

21. Annually, the Department of Social Services and the State Child Fatality Advisory Committee should jointly report statistics on child deaths from maltreatment and the number of those with prior DSS involvement.
22. The Department of Social Services and the State Child Fatality Advisory Committee should use their child fatality review findings to make recommendations to revise DSS policy or practice where appropriate.
23. The Department of Social Services should comply with the federal Child and Family Services Improvement and Innovation Act and accurately report the sources of information used to compile statistics on child maltreatment deaths. Also, if these statistics do not include deaths from the state's vital statistics department and law enforcement agencies, the agency should provide an explanation of why the data is not included.
24. The Department of Social Services should ensure that it includes child fatality statistics from all relevant sources when reporting to the National Child Abuse and Neglect Data System. These sources should include, but not be limited to, law enforcement agencies and the Department of Health and Environmental Control.
25. The State Child Fatality Advisory Committee should evaluate the feasibility of adopting the Child Death Review Case Reporting System developed by the National Center for the Review and Prevention of Child Deaths.

Incomplete Reporting of Child Fatalities

Using multiple sources of data, we identified 152 child fatalities that occurred between 2009 and 2013 for which the State Law Enforcement Division did not have a report from a county coroner, but which appeared to meet the criteria set forth in law that would require the fatalities to be reported. In 104 cases, it appears the child deaths were not reported by the coroners as required by state law, while in 48 cases, there is evidence to indicate that the fatalities were reported by the coroners. SLED, however, did not have these fatalities in its database.

Section 17-5-540 of the S.C. Code of Laws states:

> The coroner or medical examiner, within twenty-four hours or one working day, whichever occurs first, must notify the Department of Child Fatalities when a child dies in the county he serves:
> (1) as a result of violence;
> (2) in any suspicious or unusual manner; or
> (3) when the death is unexpected and unexplained including, but not limited to, possible sudden infant death syndrome.

According to the South Carolina's Children's Code, a child is defined as any person under the age of 18.

Review of Unreported Child Fatalities Using DHEC Cause of Death Data

At our request, DHEC's Office of Public Health Statistics and Information Services provided a list of child fatalities that occurred in South Carolina between 2009 and 2013, which included the causes of death for each child. We examined the causes of death to determine if the deaths met the criteria in the law of being violent, unexpected, or unexplained. We identified 141 fatalities between 2009 and 2013 for which SLED did not have a record of receiving a report from a coroner, but which appeared to meet the reporting requirement. SLED staff reviewed these cases and concurred with our conclusion that these fatalities met the criteria for being reported. Table 4.5 shows the number of fatalities and cause of death, by year.

Table 4.5: Child Fatalities for Which No Report was Found

CAUSE OF DEATH	2009	2010	2011	2012	2013	TOTAL
Gunshot Wound	9	6	9	6	9	39
SIDS	4	6	6	7	4	27
Overlay	2	7	5	8	2	24
Drowning	3	3	2	3	6	17
Hanging	1	2	2	6	0	11
Undetermined	0	0	0	4	4	8
Fire	0	0	0	2	1	3
Other	1	1	5	2	3	12
TOTAL	20	25	29	38	29	141

Sources: DHEC Office of Public Health Statistics and Information Services

These fatalities have also been grouped into one of the five manner of death categories (Accidental, Homicide, Natural, Suicide, and Undetermined). In almost half of these cases, the manner of death was listed as either accidental or natural. However, in 25 (18%), the manner of death could not be determined.

For the 141 cases identified using data provided by DHEC, 34 counties had at least one child fatality which SLED did not have in its database. We contacted the county coroners in these counties and requested information on whether the fatalities had been reported and, if not, why not. In 93 cases, we did not find any evidence to indicate that the coroners had reported the deaths to SLED as required by law. In 48 cases, there was evidence indicating coroners had reported the fatalities to SLED. However, SLED did not have the fatalities in its database.

For the 93 cases not reported, among the reasons given for not reporting included the belief that the maximum age for reporting was 16 and not 18. Coroners also indicated that the failure to report was the result of an oversight by a member of the coroner's staff. In other cases, coroners stated they did not report the case because another unit of SLED assisted with the investigation and the coroner assumed that SLED was already aware of the fatality. As noted above, state law requires that SLED's Department of Child Fatalities be notified.

In the 48 cases that appear to have been reported, coroners provided documentation indicating they had faxed the child fatality information to SLED. For other fatalities, reports were e-mailed to SLED staff, either central office administrative staff or the local agent assigned to SLED's Special Victim's Unit. Other reports were mailed to SLED. However, during this time period, the reporting process did not include confirmation of receipt by SLED, nor was it standard practice among coroners to retain documentation confirming the fatalities were reported to SLED. Therefore, in many instances, it is not possible to confirm SLED received the reports.

Additional Unreported Fatalities Meeting Reporting Criteria

We examined several other sources of data on child fatalities from DHEC, SLED, and DSS, and identified another 11 fatalities between 2009 and 2013 that should have been reported. We also found one fatality from 2014 that should have been reported.

- We obtained child homicide data for 2009 through 2012 from the Department of Health and Environmental Control's South Carolina Community Assessment Network website. Two child homicides in two different counties were on the website but were not reported to SLED. The homicides occurred in 2009 and 2012. Both children died from gunshot wounds and were 17 years old at the time of their deaths.

- Two counties reported no child fatalities to SLED from 2009 through June 2014. We contacted DHEC and obtained cause of death information for all child fatalities for residents of those two counties between 2009 and 2013. We identified three deaths that should have been reported to SLED. In two cases, the children were less than six months old when they died and cause of death was listed as sudden unexplained death. One case was listed as an accidental death from a fire.

- We also reviewed a list of child fatalities where DSS indicated that it had prior involvement with the child or family. Three deaths were not reported to SLED that should have been. Two were deaths from gunshot wounds and the other was listed as sudden infant death syndrome.

- We also reviewed a list of deaths reported by DSS to the National Child Abuse and Neglect Data System. Three deaths, one from an animal attack, one from suicide, and one listed as sudden unexpected death syndrome should have been reported to SLED, but were not.

- DSS collects information on child deaths from various sources, including local county offices and media reports. DSS sends a list of child fatalities to SLED each quarter. Most of these are deaths which would not be required to be reported by coroners because they are not violent, unexpected, or unexplained. However, one child death that occurred in February 2014 that should have been reported was identified using this method.

After we provided these cases to SLED, the agency contacted the coroners in these cases and the coroners have since reported ten of these deaths. In one county, the coroner reported he was unaware of the requirement to report these types of deaths to SLED. Other counties reported that the death was not considered a child fatality since the victim was 17.

Motor Vehicle Child Traffic Deaths Not Reported to the SCFAC

The SCFAC does not receive statistics on the number of child fatalities where an adult driving under the influence of alcohol was a contributing factor. According to the Department of Public Safety (DPS), 38 persons under the age of 18 died in collisions involving impaired drivers between 2010 and July 2014. For 9 of those deaths, the child was in the same vehicle as the impaired parent. The SCFAC also does not receive information on fatalities where the child victim was not properly restrained, the driver was under 18, or the fatality resulted from being left in a hot vehicle.

The SCFAC is mandated by law to identify patterns in child fatalities that will guide efforts by agencies, communities, and individuals to decrease the number of preventable child deaths. However, the committee does not review motor vehicle traffic deaths, except as related to injuries on private property or injury involving a pedestrian. DPS investigates all motor vehicle traffic deaths but does not report statistics to the SCFAC regarding child deaths. We could not ascertain the reason for this exemption. Also, there is currently no DPS representative on the SCFAC. It is important for the SCFAC to receive all information on child fatalities, particularly those that involve abuse or neglect, in order to identify trends in child fatalities.

Improvements in Reporting Procedures

As noted above, we found that not all coroners understood the child fatality reporting requirements. In addition, we found instances where the reporting procedure was not followed.

During the course of our review, SLED and DHEC met to discuss implementing a system where DHEC would send to SLED, every quarter, a list of all child deaths whose cause of death might fall into the categories of violent, unexpected, or unexplained. This system should assist SLED in determining if deaths are being reported by coroners, as required by law.

Prior to 2014, §17-5-540 of the S.C. Code of Laws required that coroners notify SLED when a child died "as a result of violence, when unattended by a physician, and in a suspicious or unusual manner." In 2014 the law was amended to delete the phrase when "…when unattended by a physician…." This should help clarify the law and assist coroners in meeting the reporting requirements.

SLED has revised the form for the reporting of child fatalities and has also created a uniform e-mail address that coroners can use when reporting child fatalities. These changes should help ensure that all child fatalities are reported to SLED as required by law.

S.C. Code §17-5-130 (C) requires that each newly-elected coroner complete a basic training session no later than the end of the calendar year following his election. In addition, §17-5-130 (D) requires any coroner who was elected, appointed, or employed prior to January 1, 1994, and who has served continuously since that time, to obtain 16 hours of training annually. We obtained the training agendas for 2013 coroner's basic training and the 2014 Coroner's Association annual conference; both included presentations by SLED relating to child deaths. SLED should ensure coroners are well informed regarding the changes to the child fatality reporting system.

Negative Effects of Underreporting Deaths

Between 2009 and 2013, total child fatalities declined 14%, from 717 to 614. However, between 2009 and 2013, there was a decrease of 25%, from 214 to 161, in violent, unexpected, and unexplained deaths reported to SLED. The 152 unreported cases identified in our review would represent an additional 17% of the 886 violent, unexpected, and unexplained fatalities reported to SLED between 2009 and 2013.

In addition, based on data reported to DHEC, we found that in 25 (16%) of the 152 cases, no autopsy had been performed. Without an autopsy, SLED and SCFAC may not be able to conduct a proper review of the death. While not all violent, unexpected, or unexplained deaths are the result of maltreatment, it is important that they be properly reviewed to ensure that the child was not a victim of abuse or neglect.

Section 63-7-310 of the S.C. Code of Laws includes medical examiners and coroners among the list of persons required to report any suspected cases of abuse and neglect. Section 63-7-410 provides a penalty of up to a $500 fine, six months' imprisonment, or both. However, there is currently no penalty provision in state law for failing to report a child fatality which is violent, unexpected, or unexplained to SLED.

It is important that SLED receive reports on all violent, unexpected, and unexplained deaths. SLED investigates these cases and then the cases are reviewed by the SCFAC. According to the SCFAC, failure of the state and community agencies to conduct adequate scene investigations and report child deaths in a timely manner impede efforts to prevent future deaths from similar causes. The committee is also charged with undertaking annual statistical studies of the incidences and causes of child fatalities in the state. A 2010 report by the Child Welfare Information Gateway states the child fatality review teams appear to be among the most promising current approaches to accurately count, respond to, and prevent child abuse and neglect fatalities, as well as other preventable deaths. Without knowledge of all violent, unexpected, and unexplained deaths, the committee may not be able to fulfill its mission.

Recommendations

26. The State Law Enforcement Division and the Department of Health and Environmental Control should establish a system for cross checking child fatalities in the state to ensure that all fatalities are being properly reported to SLED.

27. The State Law Enforcement Division should review the 152 child fatalities which either were not reported, or for which there is no record of a report, to determine if a case should be opened or whether they can be closed without further investigation.

28. The State Law Enforcement Division and the State Child Fatality Advisory Committee should review the training provided to coroners on the reporting of child fatalities to ensure that information is provided on which fatalities are to be reported and what procedure is to be followed for reporting the fatalities.

29. The Department of Public Safety should report statistics on all child fatalities to the State Child Fatality Advisory Committee.

30. Coroners who consistently fail to report child fatalities should be subject to the penalties contained in the mandated reporter statute.

31. The General Assembly should amend §17-5-540 of the S.C. Code of Laws to include a penalty for coroners who fail to report child fatalities to the State Law Enforcement Division.

32. The General Assembly should amend §63-11-1930 of the S.C. Code of Laws to add a representative from the Department of Public Safety to the State Child Fatality Advisory Committee.

Reporting, Screening, and Investigating Reports of Child Abuse and Neglect

In a review of the process used by DSS to screen and initiate investigations of reports of child abuse and neglect, we found that:

- The Department of Public Safety is not reporting all parents or persons acting as parents charged with child endangerment to DSS for its review.
- Establishing a central or regional system for screening reports of child abuse and neglect could result in greater thoroughness and consistency.
- After DSS implemented a community based prevention services program in FY 11-12, there was a significant decrease in the probability that child abuse and neglect reports would be investigated by DSS and a significant decrease in the number of reports that were founded after investigations.
- There was a significant increase in FY 12-13 in the number of children who were abused or neglected within 12 months of being screened-out or referred to community based prevention services.
- The decision of DSS to use private contractors to provide case management for community based prevention services reduces face-to-face contact by the department with potential victims of abuse and neglect. The use of private contractors also creates additional layers of organizations within the department's child welfare system, increasing the chance of miscommunication and that abuse and neglect will go undetected.
- Nearly one in four children whose abuse or neglect reports were accepted by DSS for investigation were not seen by a caseworker within 24 hours.
- We identified 281 instances over an eleven-month period in which DSS took more than 24 hours to decide whether to investigate a report of abuse or neglect.

DPS Reporting of Child Endangerment Arrests to DSS

The Department of Public Safety (DPS) is not reporting all parents or persons acting as parents charged with child endangerment to DSS for its review. DPS reported that, between January 2013 and July 2014, it charged 171 parents/legal guardians with child endangerment. However, in only 13 cases (8%) were these persons reported to DSS.

Section 56-5-2947 of the S.C. Code of Laws states that child endangerment occurs when any adult who has one or more passengers under 16 years old in the motor vehicle:

- Fails to stop when signaled by a law enforcement vehicle.
- Operates a motor vehicle while under the influence of alcohol or drugs.
- Drives with an unlawful alcohol concentration.
- Commits the offense of felony driving under the influence.

According to a DPS official, the department would not normally notify DSS in situations involving a traffic-related child endangerment charge unless the officer observed evidence of abuse or neglect. In that situation, the officer is required to notify the appropriate law enforcement agency and DSS. In the majority of the child endangerment situations involving traffic-related offenses, DPS officers have not been required to place the minor child in emergency protective custody. DSS was not notified if a parent, legal guardian, or a responsible adult could be located to accept custody and ensure the welfare of the minor child. However, in situations where a parent, legal guardian, or responsible adult could not be located, DSS would be notified and the child would be placed in the custody of a DSS worker.

In response to a Legislative Audit Council inquiry, DPS initiated a policy review which has resulted in policy and procedure changes to ensure that DSS will be notified of all child endangerment charges. According to DPS staff, the policy revisions will implement reporting requirements that will further enhance information sharing with DSS and will create a DSS liaison officer for the department, who will coordinate the dissemination of applicable information regarding child endangerment/abuse situations.

DPS is only able to report those individuals charged by the agency's law enforcement divisions, which may not include all individuals charged with child endangerment by other law enforcement agencies. According to a DPS official, in 2013, over 27,000 cases of driving under the influence were made in South Carolina. More than 15,000 of those cases were made by DPS, leaving approximately 12,000 DUI cases made by local law enforcement agencies and sheriffs' departments. Some of these cases may have included child endangerment charges against parents or persons acting as parents.

Section 63-7-310 of the S.C. Code of Laws includes police and law enforcement officers among the list of persons required to report any suspected cases of abuse and neglect. By not reporting to DSS individuals charged with child endangerment, children who are victims of abuse or neglect may not be receiving the services they need to ensure their safety and welfare.

Recommendations

33. The Department of Public Safety should implement a procedure to ensure that all parents or legal guardians charged with child endangerment are reported to the Department of Social Services.

34. The General Assembly should amend §56-5-2947 of the S.C. Code of Laws to require all state and local law enforcement agencies to report to the Department of Social Services child endangerment charges made against parents or legal guardians.

Current Screening Process

When an abuse or neglect report is received, usually over the telephone, a DSS intake worker attempts to gather as much information as possible from the person making the report.

The intake worker then completes a risk matrix with information about the family, the child, the home environment, and other relevant factors. Examples of additional information that may be gathered without face-to-face contact by the intake worker include DSS history, sex offender status, or information from school officials and medical personnel.

The information gathered is used by the intake worker and the supervisor to determine whether the report will be formally investigated to determine whether abuse or neglect is more likely than not to have occurred.

Some reports are “screened-out.” Reasons for screening out reports could include DSS not being able to identify the family and child in the report or maltreatment being conducted by a person who was neither a parent nor acting as a parent.

Under Title 63 of the South Carolina Code of Laws, reports that meet the definition of child abuse or neglect are required to be formally investigated.

Reports deemed to be of "moderate risk" or "low risk" to a child may be referred to community based prevention services, which are voluntary and do not include a determination of whether abuse or neglect is more likely than not to have occurred.

Need for More Centralized Screening

Because each of South Carolina's 46 counties screens its local reports of child abuse and neglect, effective statewide communication of screening policies and consistent implementation is less likely to occur.

We found examples of inconsistency, including:

- A case with a safety issue (physical abuse of children) sent to community based prevention services.
- A report that was not recorded in the DSS data system.
- A missing criminal background check.
- Criminal background checks that were not completed in a timely manner.

If intake were to be conducted centrally for all reports of child abuse and neglect in the state, the thoroughness and consistency of screening could be better ensured, although knowledge of local communities could be diminished. A regional intake process would represent a compromise between the attributes of a county process and a centralized process. According to DSS's Child and Family Services Plan for federal fiscal years 2015-2019, DSS "...will be reconfiguring the Intake process statewide by March 2015 into more focused regional Intake Hubs with a smaller well trained force...."

Recommendation

35. The Department of Social Services should screen reports of child abuse and neglect centrally or regionally.

Implementation of Community Based Prevention Services (CBPS)

In FY 11-12, DSS began implementation of a program in which parents and persons acting as parents, who have been reported to have abused or neglected a child, are offered community based prevention services when the department worker determines that an investigation is not warranted because there is not a "substantial risk" of harm to the child. Examples of the services offered to families include mental health counseling, parenting classes, and alcohol and drug abuse counseling. CBPS cases are managed by private organizations with DSS contracts that receive case referrals from DSS.

Following the implementation of the CBPS program, however, there was a decrease in the probability that a child listed in a report of abuse or neglect would be included in an investigation. There was also an increase in the number of children who were victims of abuse and neglect after being screened out or referred to CBPS in the previous 12 months.

We do not recommend that the community based prevention services program be discontinued. We do, however, recommend that DSS improve its management of the program.

State Law

S.C. Code §63-7-910(D) states:

> The department may contract for the delivery of protective services, family preservation services, foster care services, family reunification services, adoptions services, and other related services or programs.

However, S.C. Code §63-7-920(A)(1) and §63-7-20(4) require DSS to determine whether all reports of suspected child abuse or neglect accompanied by "substantial risk of physical or mental injury to the child" are founded.

Under their contracts with DSS, the CBPS providers are not authorized or required to determine whether a case is founded.

Effectiveness of CBPS at Protecting Children

Table 5.1 shows that the total number of children in abuse and neglect reports declined by 561 (1.0%) from FY 10-11 through FY 12-13, while children in the CBPS program increased from 0 to 23,198.

During the same period, there was a 10,920 (54.4%) decrease in the number of children in reports that were screened out, meaning it is likely that many of the reports that would have been screened out prior to the CBPS program were referred to CBPS services after the program was implemented.

Significantly, there was also a 12,839 (33.7%) decrease in the number of children included in child abuse and neglect investigations from FY 10-11 through FY 12-13 and a 1,186 (10.4%) decrease in the number of children included in founded reports following investigation.

The probability that a child listed in a report of abuse or neglect would be included in an investigation declined from 65.5% in FY 10-11 to 43.9% in FY 12-13. The probability that a child listed in a report of abuse or neglect would be included in a *founded* investigation declined from 19.5% in FY 10-11 to 17.7% in FY 12-13.

Because the number of children in abuse and neglect investigations decreased significantly after implementation of the CBPS program, we analyzed the number of children who became victims of abuse or neglect after being screened out or referred to CBPS in the previous 12 months. Table 5.2 shows that this number increased by 1,355 (114%) from FY 10-11 through FY 12-13.

Table 5.1: Number of Children in DSS Abuse and Neglect Reports Sorted by Screening Decision

Screening Decision	Fiscal Year					Change From FY 10-11 Through FY 12-13
	08-09	09-10	10-11	11-12	12-13	
Screened Out	18,610 (33.1%)	19,061 (32.1%)	20,080 (34.5%)	16,694 (29.1%)	9,160 (15.9%)	-10,920 (-54.4%)
Accepted for Investigation by DSS	37,534 (66.9%)	40,378 (67.9%)	38,120 (65.5%)	34,037 (59.2%)	25,281 (43.9%)	-12,839 (-33.7%)
Sent to Community-Based Prevention Services*	-	-	-	6,720 (11.7%)	23,198 (40.2%)	-
TOTAL CHILDREN	56,144	59,439	58,200	57,451	57,639	-561 (-1.0%)
Founded for Abuse/Neglect After Investigation	12,358 (22.0%)	11,832 (19.9%)	11,372 (19.5%)	11,682 (20.3%)	10,186 (17.7%)	-1,186 (-10.4%)

* The Community Based Prevention Services Program was implemented statewide on June 1, 2012.

Source: DSS

Table 5.2: Number of Children Who Became Victims of Abuse or Neglect After Being Screened Out or Referred to CBPS in the Previous 12 Months

Fiscal Year	Screened Out	CBPS Referral	Total
08-09	1,260	NA	1,260
09-10	1,398	NA	1,398
10-11	1,173	NA	1,173
11-12	1,269	219	1,488
12-13	702	1,806	2,508

Source: DSS

In January 2013, DSS did not investigate a report of educational neglect of a six-year-old child. Although the case met the legal definition of child neglect, DSS did not investigate and referred it to CBPS, who closed the case at the end of June 2013. A DSS investigation would have included a home visit and an assessment of the safety of the reported child and his siblings. In September 2013, the child's one-year-old sibling died from lethal neglect.

Table 5.3 shows that in 2012, four children died of unnatural causes during CBPS involvement. In 2013, one child died of an unnatural cause during CBPS involvement.

Table 5.3: Number of Children Who Died of Unnatural Causes During CBPS Involvement

2012	2013
4	1

Source: DSS

Decision to Use Private Organizations to Provide Case Management for CBPS

Unlike other states, DSS has contracts with private organizations to provide case management for community based prevention services. The private organizations that have these contracts are allowed to subcontract with other private organizations to provide case management and other services.

DSS staff are not required to see a child before she is referred to community based prevention services. Using private contractors also increases the complexity and miscommunication that can accompany the addition of organizations to an already complex system.

The decision of DSS to use private contractors for case management in this program reduces face-to-face contact by the department with potential victims of abuse and neglect and may increase the risk that abuse and neglect will go undetected. The increased risk from contracting out case management is particularly important due to the fact that the number of children in abuse and neglect investigations conducted by DSS declined by 12,839 (33.7%) after the community based prevention services program was implemented.

Finally, because DSS has decided not to use its staff for low- and moderate-risk cases sent to community based prevention services, new DSS caseworkers are required to begin their careers with high-risk cases, where the opportunity for mistakes due to inexperience may be greater.

In-House Case Management in North Carolina and Georgia

Officials in North Carolina and Georgia indicated that their agencies screen referrals into two categories of risk based on information obtained from reporters. However, both state officials indicated that their agencies provide case management services to lower-risk families. The two states do not contract out assessment, case management, and similar functions as South Carolina does. According to a North Carolina official, that state has begun a pilot program in two counties to send screened-out referrals to private providers in those counties to provide case management services for those families.

Recommendations

36. The Department of Social Services should ensure that reports that meet the definition of child abuse and neglect in Title 63 of the South Carolina Code of Laws are formally investigated.

37. The Department of Social Services should use only its staff to provide case management for community based prevention services.

Independent Review Finds Inadequate Screenings

In 2014, the National Resource Center for Child Protective Services (NRCCPS) conducted quality assurance reviews of ten county DSS offices in South Carolina. It sampled cases from 2013 and 2014. Some of the findings from NRCCPS were:

- In 23% (71 of 232) of the cases, a DSS history check was not thoroughly completed.
- 23% (32 of 140) of CBPS cases did not have their safety assessment done at the first face-to-face contact with the family, as required by DSS.
- For 30% (3 of 10) of the cases, a safety risk factor was identified by CBPS, but the case was not referred back to DSS, as required.
- 78% (7 of 9) of the CBPS cases where high risk was identified were not sent back to DSS, as required.

NRCCPS also concluded that DSS's screening process could be improved if it was done on a central or regional basis.

Delayed Investigations and Inadequate Face-to-Face Contact

In 2013, nearly one in four children (24%) whose abuse or neglect reports were accepted for investigation were not seen by a caseworker within 24 hours, as required by DSS policy. In 2013, among the state's 46 counties, the percentage of children not seen within 24 hours ranged from 3% to 39%. As a result, there is reduced assurance that abused and neglected children are being adequately protected.

S.C. Code §63-7-920(A)(1) requires DSS to "initiate" investigations of reports of abuse and neglect within 24 hours but does not require face-to-face contact. Under this less strict requirement, 2.9% of abuse and neglect investigations in 2013 were not initiated within 24 hours. Among the 46 counties, this measure ranged from 0% to 15.5%.

In addition, DSS allows employees to delay decisions on whether to investigate reports for up to 24 hours after they are received. Between July 1, 2013 and May 31, 2014, the department delayed decisions for 866 (3%) of 27,552 reports. 281 decisions during this period were delayed for more than 24 hours, 80 of which were later accepted for investigation by DSS.

Recommendation

38. The General Assembly should amend S.C. Code §63-7-920(A)(1) to require that investigations of child abuse and neglect include face-to-face contact with the victim within 24 hours of the report.

Inadequate Oversight of Abused and Neglected Children Placed With Alternative Caregivers

When there is probable cause to believe that a child is in "imminent and substantial danger" from child abuse or neglect, state law authorizes the removal of the child from her home and placement in a foster home. To ensure the safety of the child and protection of the due process rights of the parent(s), state law requires that a formal process of family court hearings and oversight be implemented.

Significantly less oversight is required by state law when a child in similar circumstances is removed from her home and placed informally with a relative or other person known to the family. DSS refers to these individuals as "alternative caregivers."

Administratively, DSS provides significantly less monitoring of children placed in alternative care than it does for children placed in foster care.

Oversight Required by State Law When a Child Is Placed in a Foster Home

According to §63-7-740 (A)(1) of the South Carolina Code of Laws, a family court may order that a child be removed from her home and taken into "emergency protective custody" without the consent of the parents or guardians if "the family court judge determines there is probable cause to believe that by reason of abuse or neglect there exists an imminent and substantial danger to the child's life, health, or physical safety."

Section 63-7-620(A)(1) states that a law enforcement officer may:

> …take emergency protective custody of a child without the consent of the child's parents, guardians, or others exercising temporary or permanent control over the child if … the officer has probable cause to believe that by reason of abuse or neglect the child's life, health, or physical safety is in substantial and imminent danger if the child is not taken into emergency protective custody, and there is not time to apply for a court order.…

Section 63-7-620(B)(2) requires DSS to place a child in a foster home or shelter after the child has been taken into emergency protective custody if the child does not need emergency medical care.

After a child has been taken into emergency protective custody by a family court judge or a law enforcement officer and after a preliminary investigation has been completed by DSS during the following 24 hours, the department is authorized by §63-7-660 to assume legal custody of the child. The department's rights as legal custodian include the right to make decisions regarding her medical care and schooling.

The family court is required by §63-7-710 to hold a hearing within 72 hours of the child's removal from his home to hear evidence and determine whether there was probable cause for the removal. An additional hearing regarding the merits of the removal must be held within 35 days of a removal petition from DSS.

Section 63-7-1620 requires that children in abuse and neglect court proceedings be appointed guardians ad litem and that the parents accused of abuse or neglect be appointed legal counsel if they are unable to afford it. The family court is also required by state law, under §63-7-1680(A), to approve a placement plan after an emergency protective custody action. A placement plan, in the form of a court order, sets forth the actions that must occur before the child is returned home. Under §63-7-1680(K), violation of a court-ordered placement plan may result in contempt of court charges and sanctions.

Less Oversight Required by State Law When a Child Is Placed With an Alternate Caregiver

As an alternative to foster care, §63-7-690 authorizes DSS to place a child with a "relative or other person," referred to by the department as an alternative caregiver . The parent(s) from whom the child is removed is informed in writing that:

> Without these protective measures, the child would be at risk of being removed from the home and placed in foster care for the child's protection during the investigation.

According to DSS officials, placing a child with a relative or someone known to the family instead of a foster parent can minimize disruption in a child's life.

When an alternative caregiver placement is made, however, state law does not require the family court to hold a hearing to determine whether there was probable cause for the removal, as would be required if the child were placed in a foster home. And, because there are no court proceedings, a guardian ad litem for the child and legal representation for the parent(s) are not required.

The alternative caregiver assumes physical custody of the child, while the parent(s) alleged to have abused or neglected the child retains legal custody, including the right to make decisions regarding the child's medical care and schooling.

Instead of a "placement plan" that would be included in an order from a family court judge if the child were in a foster home, DSS implements a "safety plan" that is not part of a court order and is not addressed in state law. The safety plan is signed by DSS, the parent(s), the alternative caregiver(s), and other relevant persons, who agree to take specific actions to protect the child, including restrictions on parental visitation. It expires after a maximum of 90 days. Following the expiration of the safety plan, DSS may extend the alternative caregiver placement. Violation of a safety plan may result in a request by DSS to the court for legal custody of the child and placement of the child in a foster home.

Less DSS Monitoring When a Child Is Placed With an Alternative Caregiver

DSS does not maintain a statewide list of alternative caregivers nor of the children placed in their care.

The department does maintain a list of foster parents and foster children. As of January 1, 2014, DSS reported having 3,315 children in foster homes. 6.2% of the children had been placed by court order in "foster homes" with a relative.

DSS also does not collect data on the rate of abuse and neglect that occurs when children are living with alternative caregivers. It does, however, collect data on the rate of abuse occurring in foster homes and includes the data in its annual report.

Conclusion

When there is probable cause to believe that a child is in imminent and substantial danger from child abuse or neglect, state law authorizes removal of the child from her home. However, the child will be given a significantly different level of oversight depending on whether she is placed in a foster home or with an alternative caregiver.

Examples of oversight *not* required when a child is placed with an alternative caregiver include:

- A probable cause family court hearing following removal of the child from her home.
- Appointment of a guardian ad litem for the child.
- Appointment of legal counsel for parents accused of abuse of neglect if they are unable to afford it.
- A court-ordered placement plan.
- DSS maintenance of a list of children placed with alternative caregivers.
- DSS tracking of the rate of abuse and neglect committed by alternative caregivers against children placed in their care.

Recommendations

39. The General Assembly should amend Title 63, Chapter 7, of the South Carolina Code of Laws to require similar oversight by the family court and the Department of Social Services:
    - When a child is taken into emergency protective custody and placed in foster care because there is probable cause to believe the child is in imminent and substantial danger from abuse or neglect; and
    - When a child in similar circumstances is placed with relatives or other persons.
40. The Department of Social Services should develop and maintain a statewide list of alternative caregivers, their addresses, their phone numbers, and the children placed in their care.
41. The Department of Social Services should maintain data on the rate of abuse and neglect committed by alternative caregivers against the children placed in their care.

Non-Competitive Contracts, Inadequate Data, and Use of Performance Measures

In this chapter, we note a lack of competitive procurement methods by DSS when obtaining training, consulting, and other services from outside organizations. By selecting providers through a non-competitive procurement process, DSS has restricted other qualified providers from offering their services. Also in this chapter, we identify ways to improve the department's use of data in managing its child welfare services. Finally, we note that the department could improve its processes for determining the root causes of underperformance within the organization.

Non-Competitive Contracts

We reviewed DSS contracts with entities paid to assist the department in managing its child welfare services. A contract between DSS and Winthrop University for $20 million and two other contracts between DSS and the University of South Carolina for $50.8 million were the result of non-competitive procurement methods. We also identified an improper DSS emergency procurement for $719,000.

These non-competitive procurement methods reduce the probability that the vendors selected were the best combination of quality and price. They also can create the perception that contract awards are based on favoritism.

State Procurement Requirements and Exemptions

Section 11-35-1550 of the S.C. Code of Laws requires that purchases exceeding $2,500 be made through a competitive procurement method. For contracts exceeding $50,000, §11-35-1520 requires a formal, competitive sealed bidding process.

Certain purchases, however, are exempt from the above requirements, meaning that state agencies have the option of using competitive or non-competitive procurement methods.

Section 11-35-4840 of the South Carolina Code of Laws contains an exemption that states:

> Any public procurement unit may enter into an agreement in accordance with the requirements of Articles 5 and 15 of this chapter with any other public procurement unit or external procurement activity for the cooperative use of supplies or services under the terms agreed upon between the parties; provided, that such cooperative use of supplies or services shall take place only when the public procurement units have good reason to expect the cooperative use to be more cost effective than utilizing their own supplies and services.

A March 22, 1994, State Budget and Control Board exemption to the state procurement code states that:

> In accord with Section 11-35-710 of the Consolidated Procurement Code, [the Board] delegated to the Office of General Services the authority to exempt contracts between state government agencies under Section 11-35-4830 and 11-35-4840 for supplies or services provided a cost justification is submitted to the Office in advance. The following types of contracts between state government agencies shall be exempt from the Consolidated Procurement Code and submission to General Services is not required:
>
> (1) agreements between state government agencies which are mandated by federal or state laws; and
>
> (2) services agreements between state government agencies for services authorized by that agency's enabling legislation as its purpose, duty, or mission.

Non-Competitive Memorandums of Understanding and Agreement

In 2011, DSS signed a non-binding memorandum of understanding with Winthrop University which is potentially worth $20 million. In 2011, and again in 2012, DSS signed non-binding memorandums of understanding with the University of South Carolina (USC) which is potentially worth $50,817,141. Under these agreements, the universities perform a variety of tasks for DSS, such as training, technical assistance, and quality assurance of programs. Not all of the services pertain to child protective services.

Although DSS submitted a written cost justification to and obtained approval from state procurement officials for the above non-competitive contracts, DSS had the option of using competitive procurement methods. It is questionable whether cost effectiveness can be ensured by DSS for these university contracts without a competitive procurement process.

In addition, DSS has memorandums of agreement with group homes and substance abuse treatment providers around the state. These agreements are for the group homes to provide living arrangements for certain children in foster care as well as the children's parent(s), and to provide substance abuse treatment for the parent(s). By selecting these providers through a non-competitive procurement process, DSS restricted other qualified providers from offering their services.

Emergency Procurement

In 2011, DSS entered into an emergency procurement contract with a private organization to maximize federal revenues, improve child welfare services, and improve economic welfare-to-work services at the agency. The contract was for $719,000 over a seven-month period in 2011. This contract did not meet the requirements of state law regarding the use of emergency procurements.

State law exempts agencies from using competitive procurement methods when goods or services need to be obtained quickly because of an emergency. S.C. Regulation 19-445.2110 states that an emergency procurement may be used in a "situation which creates a threat to public health, welfare, or safety such as may arise by reason of floods, epidemics, riots, equipment failures, fire loss, or such other reason…."

Conclusion

By engaging in non-competitive procurement when more than one source exists for the good or service and there is not an emergency, DSS is precluding other providers from access to state government business. Even when allowable under state law, non-competitive procurement may prevent the department from getting the best combination of quality and price. Non-competitive procurement can also create the perception that the contract awards are based on favoritism.

Recommendations

42. The Department of Social Services should use competitive procurement methods when there are multiple sources available for a good or service purchase costing more than $2,500 and there is not a legally authorized emergency.

43. The Department of Social Services should comply with state procurement laws and regulations.

Data Improvements Needed

During our review we found instances in which the department does not routinely collect or analyze key categories of data on a periodic basis that could assist in managing its child welfare services. Also, some of the data the agency does produce has not been reliable. Addressing these instances of inadequate and unreliable data will improve the analytical capabilities of DSS and improve the agency's ability to monitor improvement.

DSS does not periodically analyze salaries paid by employers with whom the department competes for employees. It also does not collect employee training and certification records or maintain a central listing of alternative caregivers who care for children removed from their homes due to abuse or neglect.

Examples of unreliable data produced by the department include child abuse and neglect deaths and employee turnover.

Specific recommendations regarding these areas in need of improvement are on pages 13, 15, 19, 35, 42, and 56 of this report.

Insufficient Attention to the Root Causes of Underperformance

DSS has developed multiple measures of child welfare service performance. Although these measures can be useful in quantifying underperformance, the department has given insufficient attention to determining the root causes of underperformance. As a result, the probability of significant long-term improvement may be diminished.

Performance Measures Used by DSS

The department has developed performance measures, accompanied by numerical goals, for its county child welfare staff. Examples of these measures include:

- Percentage of child abuse and neglect investigations that were initiated within 24 hours.
- Child abuse and neglect investigations that exceeded the statutory maximum of 60 days.
- Instances of abuse and neglect in foster homes, group homes, and child care settings.
- Children in child protective services cases who received required monthly face-to-face caseworker visits.
- Average number of months spent by foster children in foster care.
- The percentage of foster children with overdue court hearings.

Root Cause Analysis

DSS has not sufficiently addressed the root causes of underperformance in its child welfare programs. Examples of potential root causes that have been given insufficient attention include inadequate employee qualification requirements (see p. 7), a lack of central monitoring of employee training and certification (see p. 14), and no maximum employee caseload standards (see p. 21). We also found that some of the data used to manage the department is unreliable, further impeding management's ability to determine root causes (see p. 60).

A root cause can be defined as the initial factor(s) or most basic cause(s) in a sequence of events leading to a specific outcome. Root cause analysis generally focuses more on the systems and processes within an organization than specific employees. For a root cause to be relevant to reducing or eliminating underperformance, it must be controllable by the organization.

Effects of Not Focusing on Root Causes

Insufficient attention to the root causes of underperformance can result in disproportionate attention given to secondary causes. For example, a company could penalize employees for exceeding production cost limits even though a root cause may be the company's inadequate system of employee training.

In addition, disproportionate attention on the deficiencies of specific employees for not meeting numerical goals can cause employees to focus on meeting the goals to the detriment of the clients. For example, in reaction to management concerns about high production costs, employees may lower costs by reducing quality.

Recommendation

44. The Department of Social Services should ensure that it has a process for determining and eliminating root causes when analyzing underperformance within its child welfare services.

Agency Comments

DSS
Serving Children and Families

AMBER E. GILLUM
ACTING STATE DIRECTOR

NIKKI R. HALEY
GOVERNOR

October 2, 2014

Mr. Perry K. Simpson, Director
Legislative Audit Council
1331 Elmwood Avenue, Suite 315
Columbia, SC 29201

Dear Mr. Simpson:

The Department of Social Services (DSS) acknowledges that challenges currently exist for its child welfare services and we share the sense of urgency expressed by so many to solve them. We welcome the assistance of those who would constructively join us our efforts to improve child welfare services and to protect the children of South Carolina.

In addition to working with your team, DSS has been engaged in a systematic and comprehensive review of its child welfare services (CWS) programs. We have moved forward with a number of improvements developed through our own review and gotten a head start on other improvements sparked by the LAC's work.

Caseloads and the distribution of cases have come up frequently in this process. In August 2013, DSS began analyzing caseloads as part of a larger effort to set caseload standards. DSS recently submitted those proposed standards to the federal Administration for Children and Families (ACF). Since proposing the standards, DSS has initiated an aggressive staffing plan to identify qualified candidates for new positions and retain experienced caseworkers.

According to a publication by the Children's Bureau in 2004, annual turnover rates for child welfare caseworkers nationally were between 30 and 40 percent, with the average duration of employment lasting less than 2 years. Accordingly, we are also working to retain caseworkers through new opportunities for growth, increased pay, and enhanced supervision.

Below, DSS outlines where it agrees and disagrees with assumptions, analysis, and recommendations made in the final report**.**

Hiring and Training of Child Welfare Staff

Certification
DSS has identified a Learning Management Systems (LMS) available through State contracts that will meet the needs of the agency. Once this LMS product is implemented, DSS will use it to track certification and training, create learning plans, and deliver online training.

Hiring & Training
In May 2014, DSS developed a comprehensive plan to expedite the process of bringing staff onboard. Progress made to date includes:

- Funded new positions within the existing budget;

- Increased hiring across the state;
- Streamlined the hiring process to allow counties to fill vacancies more quickly;
- Instituted group interview process for identifying the most qualified candidates for second interviews; and
- Ongoing collaboration with DEW and other agencies

In 2011, DSS began a strong training program for new caseworkers, which provides the knowledge and skills necessary for quality services to children and families. County and regional offices have indicated that, upon completion of Child Welfare Basic (CWB) training, caseworkers demonstrate the required competencies.

DSS, in partnership with the USC College of Social Work, recently restructured CWB to increase capacity for aggressive hiring. The revised CWB maintains 19 classroom days and content of training, but gets caseworkers on the job faster by removing the time between in-class learning sessions. DSS reduced the training from 12 weeks to 6 weeks by removing the time between in-class learning sessions.

With careful attention to retaining quality and consistency, DSS and USC have also more than doubled the capacity to deliver CWB, enabling more staff to complete training simultaneously. The USC Children's Law Center continues to provide excellent trial preparation training for our new staff, a critical component of caseworker certification.

Turnover

Addressing high turnover rates is an important aspect of resolving high caseloads, improving service quality, and boosting employee morale. Turnover for child welfare caseworkers in South Carolina[1] and across the nation is driven by stress, low salaries, high workload, and inadequate supervision. It is imperative that DSS continue to preserve the skilled and qualified workforce it currently has by addressing turnover rates. DSS is working to drive down turnover by:

- Instituting a salary increase for county child welfare caseworkers and supervisors, effective November 1, 2014. New positions hired on or after October 2, 2014 will be on-boarded at the new base salary;

[1] The LAC report states that the DSS caseworker turnover rate between 2011 and 2013 exceeded 65%. DSS has concerns about the methodology used to arrive at this figure.

The LAC calculated the annual turnover rate for human services caseworkers for 2011 (16.1%), 2012 (23.2%), and 2013 (28.8%) by dividing the "number of employees leaving the job" that year (the numerator) by the average number of employees for that year (the denominator).

The LAC then converted these three individual years into a three year total figure. In doing so, the numerator and denominator were not converted to three-year figures in the same manner. The numerator of 407 represents the sum of the employees leaving for the three years, while the denominator of 621.5 appears to represent an average number of employees for the three years.

By using a consistent method for both the numerator and denominator of taking the average number of employees leaving the job in each of the three years and dividing it by the three-year average number of employees, the average three-year turnover rate would be approximately 22%, not 65.5%.

The decision to add numerators for three years appears to be unscientific. Adding year after year of employees leaving while maintaining an average for the number of employees will naturally produce high turnover percentages. If the LAC were to apply its method to analyze turnover for a 5, 10, or 30-year period, they would produce even more inflated numbers, eventually reaching and exceeding 100% as individuals retire and otherwise separate from the agency.

- Allocating 67 new caseworker assistant positions to counties in November 2014 to provide support to frontline practitioners, allowing them to increase their face-to-face time with children and families;
- Implementing new lead worker positions to incentivize exceptional casework and create opportunities for advancement for frontline practitioners. Lead workers will serve as a mentor to his/her colleagues and provide leadership within his/her unit; and
- Continuing to refine a career ladder for child welfare staff in the field and monitor its impact on retention.

We also need to improve succession planning for those in leadership. One third (33.3%) of the county directors who left their job departed the agency in retirement, and only 7.4% of county directors who left their job did so as the result of a dismissal. Recognizing that individuals are promoted, advance in their career to other jobs, or retire after years of service to the state – the agency should do more to promote smooth, staggered transitions in the workforce.

Caseload Management and Distribution of Staff

In their 2006 review of DSS, the LAC noted that "computing caseload standards is not an exact science, and there is currently no universally accepted formula for computing caseloads." While this remains true, DSS is developing a methodology for calculating child welfare caseloads to measure progress toward the caseload goals described above.

DSS has begun to share cases across county lines. Working across county lines, however, does not necessarily amount to equalized workload. Variables like travel time to monthly visits with each family member and child, to parent and child visitation, and to mental health and medical appointments influence workload. Accordingly, workers in counties with significantly differing characteristics, like population density or remote population centers, will not have identical caseloads. Additionally, DSS must maintain services in each of the 46 counties to respond in appropriate timeframes.

Child Fatalities

DSS agrees with the LAC's statement that data on child maltreatment deaths is not a reliable measure of agency performance. DSS data on child deaths was reported for a different purpose and was never purported to be an analysis of all maltreatment deaths in South Carolina.

To enhance public awareness and strengthen prevention efforts, DSS will prepare a written report when an investigation results in a determination that child abuse or neglect caused a child fatality or serious injury.

Unless release of the report would threaten safety or well-being of, or harm a child, the child's parents, or family, or when releasing the report would impede a criminal investigation or endanger a reporter of child abuse or neglect, the information will be published on the agency's website. These reports will include:

- age and gender of the child; description of any previous child abuse/neglect reports or investigations that are pertinent to the fatality or serious injury; the result of any such investigations; and the services provided / actions taken by DSS on behalf of the child.

South Carolina Code § 63-7-940 makes use of information contained in "unfounded" reports confidential. Access to and use of information in unfounded cases is strictly limited and therefore, reports of child fatalities will not include information contained in unfounded reports.

ACF has reviewed DSS' plans to issue written reports of child fatalities. ACF advised the agency that the Child Abuse Prevention and Treatment Act (CAPTA) anticipates that reports [child fatality] will include

information from previous child abuse and neglect reports, even if the report is unfounded, when that information is pertinent to the child fatality. Having received this clarification from the ACF, DSS is pursuing an amendment to South Carolina Code § 63-7-940 to make it permissible for the agency to include information contained in unfounded reports, if that information is pertinent to the abuse or neglect that led to the child fatality.

Reporting, Screening and Investigating Reports of Child Abuse and Neglect

In 2012, DSS implemented Community Based Prevention Services (CBPS), a statewide initiative focusing on families referred DSS that do not meet the threshold definitions of child abuse or neglect or substantial risk of harm, and therefore would not trigger an investigation upon intake. The audit makes assertions about two aspects of CBPS that warrant comment:

- The CBPS program has degraded the agency's ability to protect children.
- The private provider network model should be brought in-house to DSS.

Effectiveness of CBPS at Protecting Children

The LAC's finding that CBPS has had a negative effect on agency's ability to protect children is based solely on patterns of cases that involved children initially screened out or diverted to other services but were later found to be victims of abuse or neglect. Case reviews and any additional analysis performed does not support that DSS initial screenings or referrals were invalid.

When a report is screened out, no services are provided and any additional agency involvement will only result if another report is received. When a report is referred to CBPS, the family receives services from mandated reporters who may identify additional risk factors that were not apparent during intake. When additional risk factors are identified, the report is sent back to DSS for investigation. Reports that are returned to DSS, when additional risk factors not apparent at intake are identified, are not automatically indicative of a screening error.

By contrast, in their November 8, 2013, report, the South Carolina Joint Citizens and Legislative Committee on Children noted that 6.9% of children referred to CBPS were the subject of an indicated report within the next six months (page 9).

Under the agency's traditional model, employees were often faced with the stark choice between taking no action on a case and taking action on a case that is not warranted given the facts of a report. The implementation of CBPS provides employees with an alternative that provides at-risk families with resources that were previously unavailable. Despite what the agency sees as clear benefits of CBPS, DSS intends to continue comprehensive quality reviews of the program.

CBPS Provider Network and Case Management

DSS is open to exploring any systemic changes that would have a positive impact on outcomes for children and families. The LAC recommends that CBPS services be brought into the agency, instead of using a network of private community providers. This poses several challenges to the agency, which should be considered prior to making such a significant program change.

Bringing CBPS into the agency would have the effect of bringing more families 'into the system', stigmatizing the participants as "DSS-involved families". Given that CBPS is a voluntary program, and families are more receptive when prevention services are offered by private providers, we believe this move would only serve to decrease participation in the program.

Most states that utilize their own staff to provide case management for "lower risk" families have typical alternative response (AR) models. Typical AR models serve families that meet their state's screening

criteria for CPS. However, South Carolina's model only serves those families that ***do not*** meet the State's criteria for CPS investigation. Even though there are parallels, the skills necessary to effectively serve these families are inherently different. Organizations within the community who already provide similar services are qualified and positioned to serve South Carolina's families whose problems do not rise to the level of requiring CPS investigation.

Contracts between DSS and CBPS providers are designed to ensure consistency, accountability and quality services through monitoring and oversight processes that parallel quality control processes established within DSS.

DSS does not believe that the use of private providers unduly "increases the complexity and miscommunication…" associated with cases. DSS caseworkers routinely engage in multi-agency and multi-disciplinary coordination for families that may have instances of disability, poverty, drug and alcohol abuse, concurrent criminal investigations, and other stressors that contribute to the complexity and risk of a child's environment. Put simply, the case coordination and family dynamics of a CBPS family are no more or less complex that other families that face DSS involvement.

Before a change in case management for these children and families can be considered, more research must be conducted to determine the impact it would have on the children and families served by this program. DSS will continue to seek out research on the outcomes of private vs. public secondary prevention services.

Regionalized Intake

In February of 2014, the National Resource Center for Child Protective Services (NRCCPS) conducted a review the agency's Intake Assessment Tool and found that it contains right factors to determine whether the facts indicate a need for an investigation or a prevention services response. DSS believes that improving consistency in the application of this tool depends primarily on improving the consistency and quality of training and oversight of intake workers. In response, DSS has already developed a regionalized intake plan that will rely on specialized intake workers and supervisors and will be begin implementation January 1, 2015.

Specifically, the regional intake system will:

- Improve consistency in screening calls at intake by having dedicated staff involved in the intake process and by honing the skills of intake practitioners.
- Improve the speed of accepting and processing referrals; callers will not have to wait to make referrals due to lack of available intake practitioners; intake practitioners will enter referrals directly into our database, making them instantly available to designated responders (DSS investigators and prevention partners).
- Increase the expertise of dedicated intake practitioners through the provision of mandatory training and on-going coaching.
- Improve the consistency and quality of data in CAPSS for both referrals and resource linkages.
- Increase the capacity of local management by lessening their scope of practice

Independent Review Finds Inadequate Screenings

The LAC report discusses the CBPS fidelity review conducted by the NRCCPS. Although individual statistics are presented, the total number of cases reviewed, 303, is not mentioned. The third and fourth bullet points provide percentages without proper context.

For instance, in only 10 of the 303 cases reviewed was a safety factor identified by the CBPS provider, and in only 3 of those 10 cases did the provider fail to refer the case back to DSS. This represents less than 1% of cases reviewed, not 30%. Likewise, the review found 7 CBPS cases where high risk was identified and the case was not properly sent back to DSS. This represents 2.3% of the cases reviewed, not 78% as reported. These concerns were expressed to the LAC prior to the publication of the final report.

DSS appreciates the NRCCPS' continued willingness to work with DSS to improve intake and CBPS, and was pleased that their report found that DSS' intake tool "reflects fidelity."

Reporting Child Endangerment

If a Department of Public Safety (DPS) officer has "reason to believe that a child has been or may be abused or neglected as defined in Section 63-7-20", the officer must report that suspicion to DSS, as required by SC Code Section 63-7-310. In Section 63-7-310, people in certain occupations and professions report suspected child abuse and neglect to DSS or law enforcement. DPS should be allowed to use discretion about whether the facts as presented give them "reason to believe that a child has been or may be abused or neglected," as any mandated reporter is expected to do.

CPS Investigations & Face–to-Face Contact

Face-to-face contact with a child within 24 hours may be an ideal standard but sometimes, despite diligent efforts, it cannot be achieved. Therefore, any statutory change must provide that demonstrating diligent efforts to see the child and other activities that initiate a CPS investigation within 24 hours will be acceptable when the child cannot be seen. DSS policies require that staff make every effort to make face-to-face contact within 24 hours.

Other states' statutes and policies include the requirement that diligent efforts be utilized and documented. Other states have initiation of investigation standards that range from immediately to five calendar days.

Alternative Caregivers

The LAC is correct when it states that alternative caregiver cases receive a different level of oversight than when a child is in foster care. Dissimilarities in foster care and alternative caregiver cases account for the difference in oversight. The children living with alternative caregivers were taken into emergency protective custody. Custodial rights were returned to the parents (with concurrence of law enforcement) because a preliminary investigation by DSS found that the children could be made safe without foster care placement. The safety plan is an agreement that the children would live with the caregiver while DSS investigates the case and assesses risk. Parents can give DSS notice if they no longer agree with the safety plan and DSS must negotiate a new plan, take the case to court, or ask law enforcement to assess for emergency protective custody, depending on safety or risk factors.

The LAC recommends that these cases receive procedural safeguards, including probable cause hearings. Current law allows parents to request a probable cause hearing after return of custody.

> **SECTION 63-7-700.** Emergency protective custody proceedings.
> (C) If the child is returned to the child's parent, guardian, or custodian following the preliminary investigation, a probable cause hearing must be held if requested by the child's parent, guardian, or custodian or the department or the law enforcement agency that took emergency protective custody of the child. The request must be made in writing to the court within ten days after the child is returned. A probable cause hearing pursuant to Section 63-7-710 must be scheduled within seven days of the request to determine whether there was probable cause to take emergency physical custody of the child.

The LAC recommends court oversight in ***all*** alternative caregiver cases. Before mandating a probable cause hearing and court oversight for all alternative caregiver cases, the General Assembly should consider the impact on law enforcement agencies whose officers must testify, the Family Court, Guardian ad Litem or CASA programs, SC Commission for Indigent Defense, DSS, and the families involved.

DSS collects information on alternative caregivers in each individual case and agrees with the need to improve the aggregate reporting capabilities on this data point. Efforts to upgrade the case records system to enable this capability are already in process. Once this system is developed, South Carolina will be among a very small handful of states leading the nation in the capacity and ability to track outcomes for alternative caregivers.

Non-Competitive Contracts, Inadequate Data, and Use of Performance Measures

Non-Competitive Contracts

The LAC objected to DSS' use of cost justification, an exemption from competition, to enter into Memoranda of Understanding with the University of South Carolina and Winthrop University. DSS followed a process sanctioned under the state procurement code and the LAC does not find the process was used incorrectly. DSS disagrees with Recommendation 42. DSS should comply with the state procurement code and regulations, (Recommendation 43). However, DSS should not be restricted from properly using procurement methods that are available under state law.

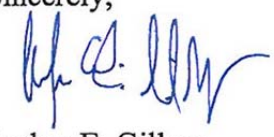
Data Improvements

DSS agrees that additional data collection and analysis would always be beneficial, and is continually working to increase access to relevant data and the capacity to analyze it. DSS has already initiated some of these efforts in the areas of turnover analysis, caseload analysis, more enhanced reporting on alternative caregiver placements, and training certification records.

DSS appreciates the times when the LAC received the agency's feedback and made corrections to the report, but instances remain of possible misinterpretation of data and information provided by DSS.

The agency will continue to work with staff and stakeholders to research evidence based best practices to resolve the issues raised by this report.

Sincerely,



Amber E. Gillum
Acting State Director

State of South Carolina
Department of Mental Health

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Mr. Perry K. Simpson
Legislative Audit Council
1331 Elmwood Avenue, Suite 315
Columbia, SC 29201

September 29, 2014

Subject: Legislative Audit Council Report – Child Fatalities

Dear Mr. Simpson,

This response was developed in coordination with State Child Fatality Advisory Committee (SCFAC) members Laura Hudson and Jennifer Buster.

The number of child fatalities which met the criteria for reporting to the State Law Enforcement Division (SLED) that were not correctly reported is shocking. Under-reporting of child fatalities results in both SLED and the SCFAC not being able to fully fulfill their collective missions.

To help address this issue, the SCFAC suggests that the South Carolina General Assembly support the passage of the Coroner's Bill introduced by Senator Hutto last session which required counties to have a properly credentialed and trained full-time Coroner.

Another underlying issue can be found in the wording of Section 63-11-1940 within the purpose and duties of the department (SLED). The wording reads:

> (A) The purpose of the department is to expeditiously investigate child deaths in all counties of the State.
>
> (B) To achieve its purpose, the department shall:
>
> (1) upon receipt of a report of a child death from the county coroner or medical examiner, as required by Section 17-5-540, investigate and gather all information on the child fatality. The coroner or medical examiner immediately shall request an autopsy if SLED determines that an autopsy is necessary. The autopsy must be performed by a pathologist with forensic training as soon as possible. The pathologist shall inform the department of the findings within forty-eight hours of completion of the autopsy. If the autopsy reveals

the cause of death to be pathological or an unavoidable accident, the case must be closed by the department. If the autopsy reveals physical or sexual trauma, suspicious markings, or other findings that are questionable or yields no conclusion to the cause of death, the department immediately must begin an investigation;

(2) request assistance of any other local, county, or state agency to aid in the investigation;

(3) upon receipt of additional investigative information, reopen a SLED case, and request in writing as soon as possible for the coroner to reopen a case for another coroner's inquest

The SCFAC suggests that sentences highlighted above be either deleted from the language, or amended to read: *"If the autopsy reveals the cause of death to be pathological or an unavoidable accident, the case may be closed by the department upon collaboration with the reporting coroner, forensic pathologist, DSS, DDSN and or the attending physician. Such cases then adopted by SLED for investigation should be reported to SCFAC pursuant to 16-11-1940(B)(5). If the autopsy reveals physical or sexual trauma, suspicious markings, or other findings that are questionable or yields no conclusion to the cause of death, the department immediately must begin an investigation;"*

Several fatality cases have been found to be homicides that were first designated as unavoidable accidents or pathological by pathologists or coroner. The time lost in the mandatory closure of the case and the discovery of the true cause/manner of death made it unnecessarily difficult to prosecute the cases, and if the cases are never reported to SLED, the likelihood of their ever being reviewed is miniscule. A complete reporting of all cases that could then be investigated promptly as to the cause/manner would increase justice being brought to children in our state whose caretakers might have considered a special needs child an expendable life.

Reason: Since no Forensic Network has been implemented pursuant to 63-5-1940 (B)(10), with consistent training in the performance of children's autopsies, varying degrees of talent by forensic pathologists throughout the state is possible. A collaborative review by SLED may find those cases that may need to be investigated.

The attached table, Child Death Statistics 2010-2012, produced by DHEC, shows a complete summary of causes of death in children and reveals that approximately 160 cases annually might have to be collaboratively screened. The SCFAC suggests that the impact on SLED and the Committee could be minimized by several telephone calls instead of a full blown investigation of these particular cases.

With regard to the comments on the accuracy of Table 4.3 Child Fatalities Reported to SLED and Those with Prior DSS Involvement, the FOI received by both SLED and SCFAC only asked for the involvement of DSS in cases, not for a review of those cases which resulted from maltreatment.

The SCFAC requests that a note be added on page 34, Child Death Reporting in Other States, line 9, that in fact, there is no "SCFAC staff".

In response to the recommendations listed:

21. The SCFAC agreed that a joint report by DSS and SCFAC on child deaths from maltreatment and those with prior DSS involvement should be reported; BUT, as LAC pointed out on page 30 and 33,

agreeing on the criteria for doing so will take some study and compromise. SCFAC Chairman will appoint a subcommittee of SCFAC to tackle this issue.

22. The SCFAC agrees, as this is mandated by statute.

25. The SCFAC desires, as it has for several years, to adopt the Child Death Review Case Reporting System; BUT, without staff and resources, such a task would be impossible. The SCFAC plans to ask for legislation to designate resources for the Committee.

28. The SCFAC agrees that collaborative review by SLED and SCFAC of the training provided to coroners on proper procedures in reporting of child fatalities should take place immediately.

29. The SCFAC agrees that DPS should report to the Committee all child fatality statistics of those 17 and under to include, but not limited to, all drivers 17 and under, all child passengers 17 and under, all occupants 17 and under not properly restrained, and any fatality of a child 17 and under whose fatality resulted from being left in a hot vehicle, or impaired/distracted driver. DPS should inquire of DSS of any known involvement with the victims or driver and/or whether the adult driver responsible for the death of a child 17 and under was a custodial parent or guardian. All impaired drivers should be noted with the levels of intoxication, if known, the identity of all known drugs and distracted drivers of known cause.

30. The SCFAC agrees that coroners failing to properly report should be sanctioned.

31. The SCFAC agrees, and suggest that such a sanction be added to the proposed Coroner's Bill being pre-filed in December 2014.

32. The SCFAC would welcome the addition of a DPS representative to the SCFAC in order to include an agreed upon procedure for reporting all child deaths 17 and under whose death occurred on the roads in SC.

Respectfully submitted,

Susan B. Luberoff

Susan Luberoff, MD
Chair, State Child Fatality Advisory Committee

Death Statistics for Residents of South Carolina Age 0 to 17 2010-2012				
Cause of Death	2010	2011	2012	2010-2012
All Causes	**687**	**665**	**651**	**2,003**
Motor vehicle accidents	61	67	52	180
Congential malformations, deformations and chromosomal abnormalities (Birth Defects)	89	88	84	261
Certain conditions originating in the perinatal period	188	205	208	601
Subtotal	349	305	307	961
Water, air and space and other and unspecified transport accidents	0	0	0	0
Other land transport accidents	0	2	0	2
Falls	2	3	1	6
Accidental poisoning and exposure to noxious substances	4	4	1	9
Accidental exposure to smoke, fire and flames	2	4	4	10
Accidental discharge of firearms	6	5	5	16
Accidental drowning and submersion	16	16	11	43
Suicide (Intentional self-harm)	15	19	16	50
Homicide (Assault)	30	23	18	71
Other and unspecified nontransport accidents and their sequelae	31	33	51	115
Sudden Infant Death Syndrome	49	45	33	127
All other external causes	10	5	3	18
Nutritional deficiencies	1	0	0	1
Whooping cough	1	0	0	1
Pneumonitis due to solids and liquids (Aspiration)	0	2	0	2
Complications of medical and surgical care	1	1	4	6
Septicemia	7	4	10	21
Cancer (Malignant neoplasms)	30	26	15	71
Diseases of heart	24	22	16	62
Chronic lower respiratory disease	6	10	8	24
Cerebrovascular disease	6	5	9	20
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	8	2	3	13
Anemias	4	3	2	9
Influenza and pneumonia	4	4	1	9
Meningitis	3	1	1	5
Nephritis, nephrotic syndrome and nephrosis	3	0	2	5
Diabetes mellitus	2	0	0	2
Hernia	2	0	0	2
Acute bronchitis and bronchiolitis	0	0	1	1
Atherosclerosis	0	0	1	1
Chronic liver disease and cirrhosis	1	0	0	1
Diseases of appendix	0	0	1	1
Meningococcal infections	0	0	1	1
All other diseases	81	66	89	236
All Causes	687	665	651	2,003
Non-CFR	338	360	344	1,042
Potential CFR	**349**	**305**	**307**	**961**
Already Assigned to SLED	193	181	146	520
Potential Additional Cases	**156**	**124**	**161**	**441**

SOUTH CAROLINA LAW ENFORCEMENT DIVISION

NIKKI R. HALEY
Governor

MARK A. KEEL
Chief

October 1, 2014

Via Hand Delivery and Email To: psimpson@lac.sc.gov
Perry K. Simpson, Director
South Carolina General Assembly
Legislative Audit Council
1331 Elmwood Avenue
Suite 315
Columbia, SC 29201

Re: SLED FINAL COMMENTS TO THE LEGISLATIVE AUDIT COUNCIL
"A Review of Child Welfare Services at the Department of Social Services"

Dear Director Simpson:

I appreciate the opportunity to comment on the Legislative Audit Council's findings and recommendations set forth in the report entitled, "A Review of Child Welfare Services at the Department of Social Services." I believe that there is a no more sacred mission than the protection of South Carolina's children. We at SLED are firmly committed to this worthwhile and noble task. Since returning to SLED in 2011, I have focused a significant amount of personal attention and resources on SLED's Department of Child Fatalities. The Department has been carefully reviewed and reorganized. Three new lieutenant positions have been added and new investigators with skills in child death investigation have been hired and assigned cases. SLED is also in the process of hiring four additional agents for the Department to fill positions granted to SLED during the most recent budget cycle. SLED has also engaged the services of an expert who is a Board Certified Child Abuse Pediatrician to conduct a monthly review of cases and to provide training for all agents assigned to the Department. Accordingly, it is noteworthy that, even prior to knowledge of this audit, SLED had taken and had committed to take significant and beneficial actions to improve the capability, quality, and processes of the Department in the interest of protecting South Carolina's children.

More resources for SLED's Department of Child Fatalities will also allow the Department to continue to improve the processes by which coroner's reports are submitted and the processes by which these submissions are received and handled by the Department. SLED is committed to enhancing the Department's communication with South Carolina's coroners and their staffs because we believe a better working rapport between the Department and the individual coroners' offices is beneficial to all. The ultimate goal of these actions is to insure that all required child fatalities are reported and that all such reports by coroners ultimately appear in the Department's database so that the Department and the State Child Fatality Advisory Committee can review these cases.

In response to specific findings in this report, SLED notes the following: On Page 36 of this report the Council found that "Not all violent, unexpected, and unexplained child fatalities are being reported and reviewed, as required by law." The report also identifies 152 such child fatalities "for which the State Law Enforcement Division did not have a report from a county coroner, but which appeared to meet the criteria set forth in the law." It is noted on Page 36 that "[i]n 104 cases, it appears the child deaths were not reported by the coroners as required by state law, while in 48 cases, there is evidence to indicate that the fatalities were reported by the coroners" that were not in the database. However, on Page 48, it is more accurately noted that:

> [i]n the 48 cases that appear to have been reported, coroners provided documentation indicating that they had faxed the child fatality information to SLED. For other fatalities, reports were e-mailed to SLED staff, either central office administrative staff or the local agent assigned to SLED's Special Victim's Unit. Other reports were mailed to SLED. However, during this time period, the reporting process did not include confirmation of receipt by SLED, nor was it standard practice among coroners to retain documentation confirming the fatalities were reported to SLED. Therefore, in many instances, it is not possible to confirm SLED received the reports.

SLED takes issue with any implication, intentional or unintentional, that SLED's Department of Child Fatalities did in fact actually receive each of these 48 coroner attempts to submit the required information and that the Department simply failed to properly process this submission. There is no actual evidence or proof that the Department did, in fact, receive each attempt made by a coroner to submit the required information. SLED does not dispute the contentions of the coroners who indicate that they did, in fact, make good faith attempts to send the required information to the Department. However, these assertions are simply not evidence that SLED's Department of Child Fatalities did in fact receive each and every one of these 48 attempts and did not enter the information into the database. As such, any implication in this report, intentional or unintentional, that SLED's Department of Child Fatalities did, in fact, actually receive each of these 48 cases is unfounded. As noted on Page 48, it is simply not possible to confirm that the Department of Child Fatalities received these reports.

However, it is noteworthy that even before this audit, SLED had already taken significant strides in alleviating the potential that cases could go unreported in the future. The Department has streamlined the preferred submission form for coroners to use and the Department has also created a uniform email address for the entire Department. This email address is also now accessible to multiple individuals within the Department to further insure proper processing of coroner submissions. SLED is also working with and through the South Carolina Coroner's Association to communicate uniform messages to the coroners regarding the use of the streamlined form and the updated email address. The Department also intends to meet with each coroner face to face to discuss the updated processes for submitting and confirming receipt of reports and to facilitate better communication between the Department and the coroners. Some of these face to face meetings have already occurred.

SLED is committed to working with the coroners to develop a verification process whereby coroners can confirm that the Department has, in fact, received all attempted submissions. On any future email submission to the Department's email address, a response email from the Department confirming receipt will be generated. On all other submissions (i.e. those sent via fax or U.S. mail), SLED would like to receive a follow up telephonic communication from the coroner's office to confirm that Department did receive the fax or mailing. SLED will continue to work on the implementation of these practices with the individual coroners.

SLED also intends to better educate the coroners to dispel assumptions that SLED's involvement in a particular case negates a coroner's reporting requirements to the Department of Child Fatalities. This is mentioned on Page 37 of the report as a reason that some coroners did not report child fatalities to the Department. It is noteworthy that the Department typically does not report to each scene of a child death. SLED has units that respond to crime scenes, such as SLED's Crime Scene Unit or SLED's regional agents; however, such responses do not constitute the required notice to the Department of Child Fatalities. That said, the Department's increased internal quality control and the Department's increased communication and training with South Carolina's coroners should insure that all cases are reported and received in accordance with the law and SLED is committed to taking the necessary action to accomplish such.

Furthermore, the Council's **Recommendation 28** is that the "State Law Enforcement Division and the State Child Fatality Advisory Committee should review the training provided to coroners on the reporting of child fatalities to ensure that information is provided on which fatalities are to be reported and what procedure is to be followed for the reporting of the fatalities." To that end, SLED and its' Department of Child Fatalities, are firmly committed to working with the State Child Fatality Advisory Committee, the South Carolina Coroner's Association, and with the individual coroners to improve the training. Moreover, SLED intends to make any employee of SLED available to conduct any training that may be requested by a

coroner or by the South Carolina Coroner's Association. Accordingly, SLED agrees with this recommendation.

In regard to **Recommendation 26**, in which the Council recommends that the "State Law Enforcement Division and the Department of Health and Environmental Control ["DHEC"] should establish a system from cross checking child fatalities in the state to ensure that all fatalities are being properly reported", SLED agrees, and continues to work with DHEC on the implementation of a system whereby DHEC would transmit information to SLED's Department of Child Fatalities ("Department") as soon as is practicable so that the Department can insure that all required child deaths are properly reported. To that end, communications regarding the implementation of this system have involved employees at all levels of each agency, including each agency head. SLED has begun receiving **monthly** reports, which is already above and beyond the quarterly reporting that was discussed on Page 40 this report. SLED would also like to take this opportunity to thank DHEC, and Director Templeton for the tremendous assistance that has been provided to date and has been committed moving forward.

With regard to **Recommendation 27**, which is that the "State Law Enforcement Division should review the 152 child fatalities which either were not reported, or for which there is no record of a report, to determine if a case should be opened or whether they can be closed without further investigation", SLED agrees and SLED's Department of Child Fatalities has begun reviewing and will review each of the 152 child fatalities noted in this report. As of the date of this letter, the Department has opened 115 of these cases.

In conclusion, SLED gratefully acknowledges the efforts of the Legislative Audit Council. We appreciate the recommendations included in this report regarding SLED and SLED's Department of Child Fatalities. As stated before, there is no more sacred a mission than the protection of South Carolina's children. To that end, as early as 2011, SLED had begun staffing additions and implementing streamlined processes that address and should exceed the recommendations in this report. SLED is committed to continually enhancing our capabilities, quality, and processes for the provision of justice for children in South Carolina.

Sincerely,

Mark A. Keel
SLED Chief

D H E C
PROMOTE PROTECT PROSPER
Catherine B. Templeton, Director
Promoting and protecting the health of the public and the environment

October 1, 2014

By Hand Delivery and E-mail
Perry K. Simpson, Director
South Carolina Legislative Audit Council
1331 Elmwood Avenue, Suite 315
Columbia, South Carolina 29201

Re: DHEC Comments to LAC Report Entitled "A Review of Child Welfare Programs at the Department of Social Services"

Dear Mr. Simpson:

Pursuant to your letter of September 24, 2014, the South Carolina Department of Health and Environmental Control ("DHEC") has reviewed the excerpt entitled, "Chapter 4 – Child Fatalities," from the Legislative Audit Council's ("LAC") report entitled, *A Review of Child Welfare Programs at the Department of Social Services.* As requested, DHEC has prepared comments to the report. DHEC's comments are enclosed herewith. In the event the LAC requires additional information concerning these comments, please let us know.

Sincerely,

Catherine Templeton

Catherine B. Templeton

Encl.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

COMMENTS CONCERNING LEGISLATIVE AUDIT COUNCIL'S REPORT ENTITLED *A REVIEW OF CHILD WELFARE PROGRAMS AT THE DEPARTMENT OF SOCIAL SERVICES*

The Department of Health and Environmental Control ("DHEC") appreciates the opportunity to provide information to the Legislative Audit Council ("LAC") to further the LAC's review of Child Welfare Programs at the Department of Social Services, particularly as those programs relate to child fatalities in South Carolina. While DHEC is not charged with monitoring child deaths and is not statutorily required to report child deaths to the South Carolina Law Enforcement Division ("SLED"), DHEC is committed to providing as much information as possible to assist SLED in determining whether coroners are reporting suspicious child deaths to SLED as the coroners are required to do by law. In June of 2014, SLED requested that DHEC begin providing statistical information to SLED related to death certificates in which coroners note suspicious deaths to use as a check on the information currently provided by coroners. Since that time, DHEC and SLED have been working cooperatively to establish a system which will allow SLED to cross-reference information received from coroners to ensure coroners are reporting suspicious child fatalities in accordance with statutory requirements. DHEC has begun providing this information to SLED and looks forward to continuing to assist SLED in this way.

South Carolina Department of Public Safety

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NIKKI R. HALEY
GOVERNOR

LEROY SMITH
DIRECTOR

September 30, 2014

Mr. Perry Simpson, Director
Legislative Audit Council
1331 Elmwood Avenue
Columbia, S.C. 29201

Dear Mr. Simpson:

Please know my office received your letter dated September 24, 2014 along with the Legislative Audit Council's final draft excerpts entitled "*Motor Vehicle Traffic Deaths Not Reported to the SCFAC*" and "*DPS Reporting of Child Endangerment Arrests to DSS*".

As requested, we have reviewed the drafts and have prepared our final comments which are now attached. It is my understanding that an electronic copy has already been forwarded to you by Mr. Sid Gaulden of my staff.

Again, thank you for the opportunity to contribute to this most important subject matter. Please do not hesitate to call on me if you have any questions or need further information.

Sincerely,

Leroy Smith
Director

LS/bb

Attachment

Motor Vehicle Child Traffic Deaths Not Reported to the SCFAC

"The SCFAC also does not receive information on fatalities where the child victim was not restrained, the driver was under 18, or the fatality resulted from being in a hot vehicle."

Final comment from DPS, regarding the aforementioned statement:

As tragic as those deaths are, children who die as a result of being left unattended in a hot (parked) vehicle are not classified as traffic fatalities. Such cases would be referred to the appropriate local law enforcement agency or sheriff's department for investigation.

As noted on Page 44 of the Legislative Audit Council report, DPS, in response to the initial LAC inquiry, conducted a policy review which resulted in changes to ensure that DSS would be notified of all child endangerment charges and that SCFAC would receive timely reports on all traffic fatalities involving persons under the age of 18.

DPS has implemented the policy and procedure changes to ensure all statistical information regarding traffic fatalities and fatal crashes involving persons under the age of 18 are reported to the SCFAC.

Policy and Procedure for Reporting Motor Vehicle Traffic Fatalities for Persons Under the Age of 18

Policy

The Office of Highway Safety and Justice Programs (OHSJP), a division of the South Carolina Department of Public Safety (SCDPS), will report all traffic fatalities for persons under the age of 18 (hereto forward known as "child traffic fatality") to South Carolina's State Child Fatality Advisory Committee (SCFAC).

Procedure

1. On each business day, an Analyst in the Fatality Analysis Reporting System (FARS) section, housed within OHSJP, will examine all available resources for the purpose of identifying child traffic fatalities.

2. On each business day, within 24 hours of identifying a child traffic fatality, the FARS Analyst will provide the SCFAC designee the following information for child traffic fatalities, when available: first, middle and last name of deceased, date of birth, date of collision, date of death, county of collision, investigating jurisdiction, seating location, and restraint usage. A copy of the collision report (TR-310) form will be provided to the SCFAC designee as soon as it becomes available. The FARS Analyst

will also provide a copy of this information and collision report form to SCDPS's Department of Social Services (DSS) liaison.

3. By the 10th day of each month, the FARS Analyst will provide to the SCFAC designee a reconciliation report for child traffic fatalities that occurred during the previous month. The reconciliation report will include the following information for child traffic fatalities: first, middle and last name of deceased, date of birth, date of collision, date of death, county of collision, investigating jurisdiction, seating location, restraint usage, and collision report form completion/submittal status. The FARS Analyst will also provide a copy of the reconciliation report to the SCDPS's DSS liaison

Please see the table below for information regarding traffic fatalities and fatal crashes involving persons under the age of 18 from 2010-2014, as of August 17, 2014. The table represents fatalities by person type: either the driver or non-driver. Non-driver status can include motor vehicle occupants, pedestrians, or bicyclists, etc.

Table 1: Traffic Fatalities for Persons under the Age of 18, 2010-2014 (2013 & 2014 data are preliminary)

Person Type	Number Killed (Under Age 18)	Percentage
Driver	75	32.2%
Non-Driver*	158	67.8%
Total	**233**	

*Includes motor vehicle occupants, pedestrians, bicyclists, etc.

Motor Vehicle Child Traffic Deaths Not Reported to the SCFAC

"DPS investigates all motor vehicle traffic deaths but does not report statistics to the SCFAC regarding child deaths."

Final comment from DPS, regarding this statement:

As noted in our previous response, DPS does not investigate all motor vehicle traffic deaths. As illustrated below, there were one hundred ninety-six (196) fatal collisions resulting in a

fatality of a driver or occupant under the age eighteen (18). DPS investigated 87.8% of these fatal collisions and local law enforcement agencies investigated 12.2 %.

While DPS receives all collision reports (TR-310) from local agencies, the department does not investigate all fatal collisions. Information from collision reports received by DPS from local law enforcement agencies regarding traffic fatalities and fatal crashes involving persons under the age of 18 will be reported to the SCFAC as outlined in the *Policy and Procedure for Reporting Motor Vehicle Traffic Fatalities for Persons Under the Age of 18* policy above.

This table represents fatal collisions by investigating jurisdiction

Table 2: Fatal Collisions for Persons under the Age of 18 by Investigating Jurisdiction Type 2010-2014 (2013 & 2014 data are preliminary)

Investigating Jurisdiction	Number of Fatal Collisions (Under Age 18)	Percentage
SCHP	172	87.8%
Non-SCHP	24	12.2%
Total	**196**	

Recommendations

33. The Department of Public Safety should implement a procedure to ensure that all parents or legal guardians charged with child endangerment are reported to the Department of Social Services.

Final recommendation from DPS:

DPS will continue to review and evaluate its policies and procedures to protect our most vulnerable population who are subjected to abuse and neglect. Based upon this review which was conducted in conjunction and in coordination with the Legislative Audit Council, DPS implemented policy revisions effective August 8, 2014, that significantly impacted operational procedures regarding Department of Social Services (DSS), reporting requirements for individuals charged with child endangerment.

This policy revision facilitated the creation of a DSS liaison officer for the department and solidified reporting procedures for all DPS law enforcement officers, by establishing partnerships with local DSS representatives within each enforcement Troop throughout the state. These procedures mandate the completion of specific reporting documents, to include a SCDPS incident report and a Child Custody Transfer Report in all situations where

an individual is charged with Child Endangerment or the officer observes evidence of abuse or neglect.

Policy revisions have also enhanced DPS notification procedures to DSS, by establishing a uniformed time frame of twenty-four (24) hours for DPS officers to notify the local DSS representative and provide him/her with a copy of the incident report and child custody transfer report, whenever an individual is charged with child endangerment. The DPS officer completing the notification process will document the date, time and DSS representative receiving the reports. The completed reports are then forwarded to the department's DSS liaison officer for review and dissemination. This process will cultivate and foster the partnerships established by the DPS policy revision and encourage productive information sharing.

In conclusion, while DPS has never comprised the safety or welfare of a child, the department will continually review and evaluate existing policies and procedures to protect our most vulnerable population, our children, to ensure their safety and welfare.

It is important to note DPS is only able to report those individuals charged by the agency's law enforcement divisions, which unfortunately may not include "all" individuals charged with child endangerment. As an example, in 2013, more than 27,000 cases of driving under the influence were made in South Carolina. Of that number 15,000 plus were made by DPS, which leaves some 12,000 DUI cases made by local law enforcement agencies and sheriff's departments -- any number of which may have included child endangerment charges. Amending section 56-5-2947 of the South Carolina Code of Laws to require all state and local law enforcement agencies to report to DSS all child endangerment charges should provide a more comprehensive picture of the extent of the problem.

Final recommendation from DPS:

> It is further recommended that a DPS representative could be added to the State Child Fatality Advisory Committee by amending section 63-11-1930 of the South Carolina Code of Laws.

SC BUDGET AND CONTROL BOARD reviewed portions of the preliminary and final draft of this report and did not wish to have comments included in the final report.

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