IN MEMORY OF

Judge Stephen E. O'Neil
Supervising Judge

Johnnie Raines
Los Angeles County
Civil Grand Jury
2001-2002

"Let their memory and promise shine within us."
Deborah Cooper

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INTRODUCTION

Los Angeles County Civil Grand Jury

FUNCTIONS OF THE LOS ANGELES COUNTY CIVIL GRAND JURY

The California Penal Code allows the superior court to impanel two grand juries, one to return indictments and another to perform the civil functions of accusation and local government oversight. The Civil Grand Jury performs the civil functions.

The Los Angeles County Civil Grand Jury is a volunteer body of 23 citizens residing within the county of Los Angeles who are charged and sworn to respond to citizen complaints and to conduct inquiries into matters of civil concern within the boundaries of Los Angeles County and its incorporated cities.

RESPONSIBILITIES OF THE LOS ANGELES COUNTY CIVIL GRAND JURY

The grand jury's responsibilities and powers are expressed in Chapter 4 of the California Penal Code (PC), Sections 3060(ff) of the California Government Code (GC) and Section 17006 of the California Welfare and Institutions Code (W&I)). There are four responsibilities specifically required of the grand jury and a wide scope of permitted ones. These required responsibilities all begin with ***"the grand jury shall . . ."***

> " . . . investigate and report on the operations, accounts and records of the officers, departments, or functions of the county including those operations, accounts and records of any special legislative district or other district in the county created pursuant to state law for which the officers of the county are serving in their ex officio capacity as officers of the districts. The investigations may be conducted on some selective basis each year.
>
> . . . inquire into the condition and management of the public prisons within the county.
>
> . . . inquire into the willful or corrupt misconduct in office of public officers of every description within the county.
>
> . . . submit to the presiding judge of the superior court a final report of its findings and recommendations that pertain to county government matters."

AREAS OF ACTION

The Civil Grand Jury's function, therefore, is the civil investigation of government; it is a "citizen watchdog" panel with an agenda of its own choosing. The jury has a dual role: it is a

deliberative body drawing conclusions from evidence, and a fact finding body, not requiring other agencies to collect information for it.

CONDUCT

The Civil Grand Jury functions lawfully only as a body. No individual grand juror, acting alone, has any power or authority. Meetings of the Civil Grand Jury are not open to the public. Law requires all matters discussed before the Civil Grand Jury, and votes taken, to be kept private and confidential. The end result of inquiries into civil matters are released to the public via a final report which is approved, prior to release, by the presiding judge or his designee, the supervising judge of the superior court.

The Civil Grand Jury represents the interest of the public, not individuals, not any organizations nor any groups with which jurors may have been associated. It is the duty of the grand jurors to think at all times in terms of public, not personal interest.

CONFIDENTIALITY

Members of the Civil Grand Jury are sworn to secrecy. All grand jury proceedings are secret. This secrecy guards the public interest and protects the confidentiality of sources. The minutes and records of grand jury meetings cannot be subpoenaed or inspected by anyone. Matters before the grand jury should *never* be discussed outside the grand jury. The Grand Juror's promise or oath of secrecy is binding for life (in perpetuity). By law, it is a misdemeanor to violate the secrecy of the grand jury room. Successful performance of grand jury duties depends upon the secrecy of all proceedings.

REQUIREMENTS TO BECOME A GRAND JUROR

Civil Grand Juror candidates must meet all of the following qualifications:

be a citizen of the United States,

be at least 18 years of age,

be a resident of the State of California and Los Angeles County for at least one year immediately prior to selection,

possess ordinary intelligence, sound judgment, and good character,

must not be serving as a trial juror in any California court,

cannot have been discharged as a grand juror in any California court within one year of the beginning date of service (July 1),

cannot have been convicted of malfeasance in office, any felony or other high crime, and cannot be serving as an elected public official.

JUROR SELECTION PROCESS

In counties over 4 million (such as Los Angeles County) the law states that there shall be 23 members of the Civil Grand Jury with 4 alternates. These 23 members are selected by an application, interview and random draw process to serve for a term of one year that begins July 1 and ends June 30.

To be considered, applicants must apply by early November. Those names are placed into a selection pool along with appointees made directly by judges. Each judge in the County may recommend two people to the pool of candidates. A panel of judges then interviews candidates, and by March the pool is reduced to qualifying candidates advanced to the next selection process. From this list of qualifying candidates, there is a random draw of 40 plus 10 alternates. A background check is made of the 40 nominees and 10 alternates. In early June, a second random draw of 23 plus 4 alternates is made from the pool of 40. On July 1, the 23 plus 4 are sworn in for service as members and alternates of the Los Angeles County Civil Grand Jury.

TIME INVOLVEMENT

The Civil Grand Jury convenes Monday through Friday and each jury determines a work schedule to meet the requirements of more than 200 work days. Plenary meetings are convened in chambers. Investigations and site visits are conducted on location. The per diem rate is $25.00, and mileage is reimbursed (currently 31 cents per mile) for travel to and from the Grand Jury Offices and for all grand jury business.

Anyone interested in serving on the Los Angeles County Civil Grand Jury and who meets the requirements should request further information from:

Los Angeles County Grand Jury Services
320 West Temple Street, 15th Floor
Los Angeles, California 90012
213 - 974 - 5814

http://grandjury.co.la.ca.us

"I don't know what your destiny will be, but one thing I know: the only ones among you who will be really happy are those who will have sought and found how to serve."
Albert Schweitzer

OATH OF OFFICE

(Penal Code §911)

"I do solemnly swear (affirm) that I will support the Constitution of the United States and of the State of California, and all laws made pursuant to and in conformity therewith, will diligently inquire into, and true presentment make, of all public offenses against the people of this state, committed or triable within this county, of which the grand jury shall have or can obtain legal evidence. Further, I will not disclose any evidence brought before the grand jury, nor anything which I or any other grand juror may say, nor the manner in which I or any other grand juror may have voted on any matter before the grand jury. I will keep the charge that will be given to me by the court."

Administered by
Judge Stephen E. O'Neil
July 2, 2001

LOS ANGELES COUNTY CIVIL GRAND JURY 2001-2002

Front Row (left to right) – Sam Hollander, Claire Stone, Marjorie H. Rhodes, Shirley (Taz) Robinson, Rick Mehling, John L. Lewis, Michelle M. Wilson, Margarett Tucker, Tammi Sharp, Shirley A. Jordan, Arthur Aratow.

Back Row (left to right) - Gunter G. Altman, Candelario Arriola, Carole Hatcher, David Cohen, Larry Higgins, James B. Avery, Sr., Richard H. Smith, Jaime Pulido, Yvonne M. White.

Los Angeles County
Civil Grand Jury 2001-2002

Full Term	Partial Term
Gunter G. Altman	Chalon Coran
Arthur Aratow	Lawrence Higgins
Candelario Arriola	Sam Hollander
James B. Avery, Sr.	Toni Maurer
David Cohen	Jaime Pulido
Carole Hatcher	Johnnie Raines
Shirley A. Jordan	Tammi Sharp
John L. Lewis	John A. Simmons
Rick Mehling	Claire Stone
Marjorie H. Rhodes	
Shirley (Taz) Robinson	
Richard H. Smith	
Floyd R. Stauffer	
Margarett Tucker	
Yvonne M. White	
Michelle M. Wilson	

"Do not, for one repulse, forego the purpose that you resolved to effect."
Antonio, in Shakespeare's *The Tempest*

Los Angeles County
Civil Grand Jury
2001-2002

VISION STATEMENT

WE, the 2001-2002 Civil Grand Jury, for the County of Los Angeles,

Having been duly sworn to uphold the oath of duty, do further pledge:

- To maintain an environment of the highest integrity;
- To promote the general improvement of all communities;
- To practice a careful consideration when listening and speaking to others; and,
- To act as a unified body when the majority rules.

SO SAY WE ALL

AUDIT COMMITTEE

BACKGROUND

Under the California Penal Code §925, 925A, 9331, and 933.5, the Los Angeles Civil Grand Jury 2001-2002 was empowered to investigate the fiscal and operational performance activities of Los Angeles County government and other local public entities. It also had authority to engage outside consultants/auditors in order to assist in its investigations. Remuneration for the outside services is provided through funds allotted to the Los Angeles Civil Grand Jury in the form of an annual budget granted by the Los Angeles County Board of Supervisors.

OBJECTIVES

The Audit Committee of the Los Angeles County Civil Grand Jury was one of four mandated committees under the California Penal Code. To that effect, the Civil Grand Jury 2001-2002 had the task of identifying outside consultants/auditors qualified to perform audits or studies selected by the different grand jury committees. Upon selection of a consultant/audit firm, the committee followed-up on progress of the audits being conducted and secured proper interim reports to that effect, in order to keep the grand jury appraised of the status of the commissioned audits/studies.

The Audit Committee also ascertained that vendor drafts of final reports were supplied to the grand jury in a timely manner and that the members of the concerned committees were present at the exit interview conducted by the auditors, prior to issuance of their final audit/study report.

METHODOLOGY

The Audit Committee established an initial crop of 18 firms selected from the county's auditor list of "approved suppliers" that might meet the grand jury criteria. An invitation to participate was extended to those firms, and a request for an expression of interest in assisting the grand jury in its potential audits or studies was issued. References for past work performed for previous grand juries or public entities was mandatory.

Of the 18 firms contacted, nine responded. The committee reviewed the nine proposals and references and then selected three that showed extensive experience in the field. After further study, the committee concluded that one firm was too small and would have difficulties handling more than one assignment. The two remaining firms were equal in experience but vastly different in pricing. The committee selected the lower priced vendor. A volume discount was negotiated by awarding all audits to the one firm. This allowed the committee to stay within its audit budget. Following the above process, the Audit Committee presented the selected firm credentials to the 2001-2002 Civil Grand Jury for approval.

By unanimous vote the firm was approved and the following audit-studies were contracted.

- Department of Children and Family Services – Child Removal Practices
- MacLaren Children's Center – Management Audit
- Sheriff's Department Biscailuz Recovery Center – Domestic Violence Intervention Program
- Los Angeles Unified School District – Analysis of California State Lottery Revenues and Expenditures

FINDINGS

It was found that the earlier a topic of audit/study was determined by the entire grand jury, the more time the Audit Committee had to secure the services of a contractor to commence the necessary work. Thereafter, the Audit Committee gave top priority to managing the delivery of the audit/study results in order to coordinate work product in the performance time allocated by each requesting committee. It is essential that all of this took place in accordance with the Edit Committee timetable for publishing of the final report.

The Audit Committee of the Los Angeles County Civil Grand Jury 2001-2002 reviewed the periodic progress reports presented by the auditors. The involved committees took notice of a number of problems encountered by the auditor in obtaining the necessary information and documentation vital to the performance of their audit assignment.

One of the problems was the delay caused by the staff or personnel of the different agencies that took endless time either to procure documentation, answer auditor's questions or set up meetings for exit interviews. From the beginning, the Audit Committee ran into a timing problem. The different committees neglected to select their audit projects early enough to allow for any delays that could occur in the course of the performance of an audit. For example, the 30-day delay in obtaining a court order to pursue the study contracted for the Department of Children and Family Services, or the procedure to be followed to draw up, review and have all concerned parties sign the contract with the audit firm.

The delays affected not only the work of the committees that commissioned the audit, but the Edit Committee whose work was of the utmost importance, and faced more than any other committee, a performance and printing deadline critical for the entire grand jury.

Above all, the Audit Committee must be comprised of members whose skills include oversight and project management of concurrent projects with delivery dates which are paramount to the completion of the final report of the entire grand jury.

The Audit Committee

CITIZEN COMPLAINTS COMMITTEE

BACKGROUND

It is the right of all Los Angeles County citizens to bring to the attention of the Los Angeles County Civil Grand Jury those matters about which they have concern. The Los Angeles County Civil Grand Jury 2001-2002 received more than 62 complaints or requests for investigation. These communications were from the general population as well as from the incarcerated population.

Before the 2000-2001 term there was one Los Angeles County Grand Jury. In 2000 the Los Angeles County Grand Jury was bifurcated (legally divided) into a Civil Grand Jury and a Criminal Grand Jury. The Citizen Complaints Committee is one of four mandated committees of the Civil Grand Jury. The other three mandated committees are Audit, Edit and Jails.

Before the bifurcation of the Grand Jury, complaints were first received by the legal advisor to review. An acknowledgment was sent to the complainant at that time by the advisor. Complaints were then passed to the jury foreperson with the recommendation of the advisor.

After the bifurcation of the Grand Jury, citizen complaints were no longer received by the advisor. They were received directly by the Civil Grand Jury or by the Grand Jury Staff. Complaints must be in writing, either in a letter or on a Citizen Complaint form. This form was studied and revised by the 2001-2002 Civil Grand Jury, and is available from the Civil Grand Jury or from the Grand Jury Staff. Included with this report, as Attachment (A) is a copy of the Citizen Complaint form. The response letter from the Civil Grand Jury to the complainant was also revised to clarify further to the complainant what other information might be needed, or to explain the reasons for possible rejection of the complaint. A copy of the revised response letter is included with this report as Attachment (B). A complete listing of citizen complaints received by the Los Angeles County Civil Grand Jury 2001-2002 is included as Attachment (C).

OBJECTIVES

The Civil Grand Jury Citizen Complaints Committee was formed to review each citizen's complaint received for evaluation and possible investigation. If appropriate, the committee then referred it to a jury committee for further investigation and resolution. If the citizen complaint was not appropriate for the Civil Grand Jury, the complaint could be forwarded to another county agency having jurisdiction, or no action was taken.

METHODOLOGY

Upon receipt of a complaint, the committee chairperson directed the jury staff to send an acknowledgement to the complainant. There was no other communication from the Civil Grand Jury to the complainant unless additional information was desired. Further action on the complaint was dependant on a vote by the entire Civil Grand Jury.

The Citizen Complaints Committee Chairperson logged in each complaint, reviewed the file, and circulated it among members of the committee for their review. The complaint was discussed in committee and appropriate action was determined. If legal advice was deemed necessary, the committee chairperson asked the grand jury foreperson to request assistance from the county counsel. Before final disposition, the file with the committee's recommended action was presented to the Civil Grand Jury. The complaint might then be referred to another committee. If found to be of a criminal nature, the complaint would be forwarded to the District Attorney's Office with concurrence of counsel. If there was no appropriate action to be taken by the Civil Grand Jury, a file was closed.

Pursuant to the governing limitations of statutes, there was limited communication between the Civil Grand Jury and the complainant. An acknowledgement letter sent to the complainant recognized only the receipt of the complaint. Communication to the complainant was limited. The communication could not indicate the resolution of the complaint, whether it was determined to be founded or unfounded, or how it was acted upon, except if these matters were discussed in a final report.

FINDINGS

There were complaints received that were not under the jurisdiction of the Civil Grand Jury, and some were otherwise inappropriate for investigation. Some complaints were from citizens of other countries, states and counties. Six complaints were from outside Los Angeles County and two were under federal jurisdiction. Some were vague and made no actual complaint. In many instances, there were insufficient facts to support the complaint. Other complaints concerned cases that were pending in the courts and could not be reviewed by the Civil Grand Jury.

Due to the limited ability to communicate directly, the complainant might have the impression that the complaint was receiving attention through investigation, when in fact that was not the case. The limited response from the Civil Grand Jury gave false hope to the complainant for a successful resolution. This limited ability to communicate directly with the complainant was the source of much frustration for the Civil Grand Jury.

A revision of the acknowledgment letter to the complainant was instituted. If the complaint was not appropriate for Civil Grand Jury investigation, the acknowledgement letter so stated, and indicated that no further action would be taken on the matter.

The Citizen Complaints Committee

ATTACHMENT (A)
Citizen Complaint Form

Los Angeles County Civil Grand Jury
The Superior Court
Criminal Courts Building
210 West Temple Street
11th Floor, room 11-506
Los Angeles, CA 90012

See Complaint Form Guidelines
opposite side for complete instructions
All forms must be signed

1. **Who**: Your Name:_____

Address:_____

City_____State,_____Zip Code:_____

Telephone:(_____)_____Extension: _____

2. **What**: Subject of Complaint. Briefly state the nature of complaint and the action of what *Los Angeles County* department, section, agency, or official(s) that you believe was illegal or improper. Use additional sheets if necessary.

_____

_____

_____

_____

3. **When:** Date(s) of incident _____

_____

4. **Where:** Names and addresses of other departments, agencies or officials involved in this complaint. Include dates and types of contact, i.e. phone, letter, personal. Use additional sheets if necessary.

_____

_____

_____

_____

5. **Why/How** Attach pertinent documents and correspondence with dates.

_____

_____

_____

_____

6. **Signed** _____ **Date:**

_____

Please see reverse side for additional instructions **10/04/01**

Complaint Guidelines

Communications from the public can provide valuable information to the Civil Grand Jury. Receipt of all complaints will be acknowledged. If the Civil Grand Jury determines that a matter is within the legally permissible scope of its investigative powers and would warrant further inquiry, additional information may be requested. If a matter does not fall within the Civil Grand Jury's investigative authority, or the jury determines not to further investigate a complaint, no action will be taken and there will be no further contact from the Civil Grand Jury.

The findings of any investigation conducted by the Civil Grand Jury can be communicated only in a formal final report, which is normally published at the conclusion of the Grand Jury's term of impanelment (June 30th).

The Civil Grand Jury has no jurisdiction or authority to investigate federal agencies, state agencies, or the courts. Only causes of action occurring within the County of Los Angeles are eligible for review. The jurisdiction of the Civil Grand Jury includes the following:

- Consideration of evidence of misconduct against public officials within Los Angeles County.

- The inquiry into the condition and management of the jails within the county.

- Investigation and report on the operations, accounts, and records of the officers, departments or functions of the county including those operations, accounts, and records of any special legislative district or other district in the county created pursuant to state law for which the officers of the county are serving in their ex officio capacity as officers of the districts.

- Investigation of the books and records of any incorporated city or joint powers agency located in the county.

Revised 10/04/01

ATTACHMENT B

SAMPLE LETTER TO COMPLAINANT

Date
Name
Address

Dear

Your letter to the Civil Grand Jury, dated has been received and is being reviewed.

The fact that members of the Grand Jury are reviewing this matter does Not mean that the Grand Jury is conducting an investigation into your complaint. Rather, a review is being done to assist the Grand Jury in deciding what further action, if any, to take. By law, the Grand Jury is precluded from communicating the result of its investigation except in one of its public report.

All communications are considered, but may not result in any action or report by the Grand Jury.

Please note that the Los Angeles County Civil Grand Jury has no jurisdiction or authority to investigate Federal agencies, State agencies or the courts. Only causes of action occurring within the County Government of Los Angeles are eligible for review.

Please review the checked items in the list below for additional comments concerning your specific complaint

____ Request for more specific facts
Your complaint contained insufficient facts for the Grand Jury to consider. If you wish the grand Jury to further review your letter, we will need more specific information.

____ Request for additional information
In order to further consider your complaint, the Grand Jury requests the following additional information:

____ No jurisdiction (State or Federal)
The Grand Jury does not have jurisdiction over the subject matter of your complaint.

____ Referral to another agency
The Grand Jury does not have jurisdiction over the subject matter of your complaint. You may wish to contact

_____

____ Suggestion for legal counsel
The matter you describe in your letter dated_____, appears to be an issue which may require you to obtain legal advice which the Grand Jury is not empowered to provide.

____ Matter is before the Courts
The matter referred to is pending before court. If you believe that The court has incorrectly resolved the matter, you may consider appealing it to a higher court.

Sincerely,
Civil Grand Jury Staff

ATTACHMENT (C)

CITIZEN COMPLAINTS COMMITTEE

The following is a listing of Complaints received by the Los Angeles County Civil Grand Jury 2001-2002.

01/69	Alleged discrimination on Federal Property
01/71	Alleged abuse by Los Angeles Health Department personnel
01/72	Ongoing feud with Workers Compensation Division
06-17-01/01	Bond Issue in Los Angeles Community College District
07-30-01/02	Alleged abuse, waste and fraud within L.A. Unified School District (LAUSD)
07-30-01/03	Complaint against Orange County by Orange County Citizen
08-13-00/04	Complaint against the State of California
08-15-01/05	Alleged discrimination against and abuse of disable person
08-15-0/106	Complaint by an inmate of a State Prison against prison personnel
08-15-01/07	Complainant resides in the Netherlands
08-23-01/08	Alleged abuse by Department of Children and Family Services
08-29-01/09	Request for cleanup of Port of Los Angeles
08-29-01/10	Alleged excessive use of force by Los Angeles Police Department
08-30-01/11	Request for investigation into death of friend
08-30-01/02	Prison inmate alleges misconduct by prison personnel
08-30-01/13	Alleged conspiracy against son by authorities
08-30-01/14	Discrimination within Torrance Police Department
08-30-01-1/5	Inmate alleges misconduct by District Attorney
08-30-01-1/6	Alleged abuse by prison personnel

09-06-01/17 Alleged police brutality

09-06-01/18 Alleged unresponsiveness of Sheriff's Department

09-06-01/19 Alleged discrimination by LAUSD

09-06-01/20 Alleged mistreatment by staff at state mental institution

09-06-01/21 Alleged discrimination because of "perceived" ethnicity

09-19-01/22 Alleged conspiracy between Board of Supervisors and Assessor's Office

09-19-01/23 Alleged police brutality

09-24-01/24 Alleged murder plot

09-24-01/25 Complaint About Fire Department Personnel Practices

10-11-01/26 Alleged corruption District Attorney's Office

10-16-01/27 Complaint against Metropolitan Transit Authority

10-16-01/28 Alleged unfair disbarment

10-16-01/29 Concern expressed over future water needs in Los Angeles County

10-23-01/30 Investigation requested into eminent domain issue

10-23-01/31 Alleged corruption in City of South Gate

10-23-01/32 Alleged abuse fiscal mismanagement in Department of Animal Care Control

10-26-01/33 Proclamation of innocence by inmate in state prison

10-26-01/34 Alleged corrupt courts in Lancaster

11-08-01/35 Alleged assault with a deadly weapon by city employees

11-13-01/36 Inmate complaint about court appointed attorney

11-13-01/37 Alleged embezzlement by prison warden

11-15-01/38 Alleged physical assault on property of a privately owned company

11-15-01/39	Alleged mental abuse by social worker at juvenile camp
11-27-01/40	Request investigation into Department of Child and Family Services
11-27-01/41	Alleged abuse at state prison
11-28-01/42	Alleged denial of Relocation Funds by Alameda Corridor Transportation Authority
12-20-01/43	Alleged discrimination by City of Los Angeles against city employee
01-11-01/44	Alleged complaint against California Franchise Tax Board
01-11-01/45	Proclamation of inmate innocence and desire to withdraw guilty plea
01-22-01/46	Alleged inappropriate ruling by Probate Court
01-24-01/47	Complaint Against Drug Enforcement Agency (DEA) alleged actions
01-25-01/48	Complaint about LACUSC Medical Center contractor overpayment
07-07-02/49	Alleged corruption of Los Angeles County Sheriff's Department and Deputy District Attorney
02-20-02/50	Alleged fraudulent tax assessment by Los Angeles County Tax Assessor
02-20--2/51	Alleged misconduct by Los Angeles County Deputy District Attorney
02-20-02/52	Alleged lack of prosecution of rapist
02-20-02/53	Alleged illegal rent increase
02-21-02/54	Alleged state office imprisonment misconduct
03-01-02/55	Alleged state prison abuse of authority and poor legal representation
03-27-02/56	Alleged conspiracy by state and court officials
03-29-02/57	Alleged falsification of inspection reports by Los Angeles County Fire Department
04-03-02/58	Alleged criminal misconduct of court judge
04-09-02/59	Alleged excess work hours in state prison by inmate
04-23-02/60	Alleged unfair selective enforcement of city codes

04-23-02/61 Alleged collusion between Downey Police Department and District Attorney's Office

04-24-02/62 Alleged racial discrimination at state prison

EDIT COMMITTEE

Grand Jury Awareness and Final Report

BACKGROUND

Penal Code §933(a) requires the grand jury to ". . . submit to the presiding judge of the superior court a final report of its findings and recommendations. . . . Final reports on any appropriate subject may be submitted to the presiding judge of the superior court at any time during the term of service of a grand jury . . ."

The Edit Committee was responsible for the production of the Los Angeles County Civil Grand Jury 2001-2002 final report consisting of the findings, conclusions and recommendations of the various studies and investigations conducted by the committees of the Civil Grand Jury. Each committee report draft was reviewed by the Edit Committee for readability and copy editing. After a review process was applied to the various reports they were assembled, compiled and edited into one final report.

The Los Angeles County Civil Grand Jury 2001-2002 was internally divided into eleven committees:

Audit
Citizen Complaints
Edit
Education
Government Operations
Health & Human Services
Jails
Public Safety
Research & Follow-Up
Social Services
Speakers & Events

Four of the committees, Audit, Citizen Complaints, Edit and Jails are standing committees with specific and mandated objectives to address. Other committees change from one Civil Grand Jury to the next, depending upon the work each jury chooses to undertake.

Each committee was responsible for determining its topics of concern, conducting studies, gathering pertinent data and/or supervising the investigations within its field of interest. The entire Los Angeles County Civil Grand Jury must approve any investigations. In some instances, a committee was aided in its investigation by the employment of an outside professional auditing firm.

OBJECTIVE

The objective of the Los Angeles County Civil Grand Jury 2001-2002 Edit Committee was to produce and publish any final reports of the Civil Grand Jury.

METHODOLOGY

Upon completion of investigations, the written reports of the committees were submitted to the Edit Committee for editing and publication. This process included review by the Civil Grand Jury Foreperson and the entire Civil Grand Jury. The County Counsel reviewed the final report for liability and consistency with statutory authority. The presiding judge reviewed the final report for compliance with the law. After review by all parties, the final report was printed and published.

The Edit Committee was responsible for selecting a vendor printer, selecting layout, format, stylization, presentation, delivery and project management. The production of the final report was a joint-venture partnership between the various committees, the Edit Committee and the printer. Production was accomplished within a limited amount of time.

Before publishing the final report, the Civil Grand Jury provided the affected agencies a copy of the portion of the report relating to that agency, two working days prior to public release. The affected agency was prohibited by Penal Code §933.05(f) from disclosing " *any of the report prior to the public release of the final report."* The ban was in affect to prevent press leaks during the two-day period when the Los Angeles County Civil Grand Jury cannot publicly comment on the contents of the report.

Distribution was made to the Presiding Judge of the Civil Grand Jury, the Los Angeles County Board of Supervisors, Superior Court Judges, the District Attorney, the Public Defender, the Probation Department, the Sheriff, various county departments, Chiefs of Police in cities throughout the county, news media, public libraries, public interest groups, and other interested citizens. Approximately 1700 copies of the final report were distributed. The final report should also be available on the Internet at **http://grandjury.co.la.ca.us**. It is hoped that this wide distribution will help to educate and encourage more citizens to apply for grand jury service.

The Los Angeles County Civil Grand Jury final reports are an excellent tool for informing the public of its work covering all inquiries and findings, and recommendations and commendations. Continuing efforts need to be made to distribute the final report to as many public interest groups, organizations, and other public venues as possible. This will help to educate and inform the citizens of Los Angeles County about the duties of the Civil Grand Jury. Other volunteers may also be encouraged to make application to serve on the Civil Grand Jury.

FINDINGS

All reports issued by the Los Angeles County Civil Grand Jury are final reports. Once issued, they must not be changed. The law does not permit minority reports, and a report cannot contain minority opinions. The Civil Grand Jury speaks with one voice, through the report of its findings and recommendations that pertain to county government matters during the fiscal or calendar year of its term. A final report is the only document through which the grand jury may communicate to the public.

It has been an honor to serve the citizens of Los Angeles County, and to be a partner in the work and production of this final report.

The Edit Committee

Edit Committee

GRAND JURY AWARENESS AND FINAL REPORT
RECOMMENDATIONS

1. The Edit Committee recommends that the Board of Supervisors continue and expand its "Grand Jury Awareness" campaign in an effort to help recruit volunteers for service on the Los Angeles County Civil Grand Jury.

2. The Edit Committee recommends that the Board of Supervisors make available to the citizens of each of their districts, through their field offices, application forms for service on the Los Angeles County Civil Grand Jury.

3. The Edit Committee recommends that the Board of Supervisors work with the Superior Court and its Jury Services staff to continue the distribution of the Los Angeles County Civil Grand Jury 2001-2002 final report, and each subsequent Civil Grand Jury final report, to the webmaster of the internet grand jury site, to post for public review via the internet.

4. The Edit Committee recommends the Board of Supervisors work with the Superior Court and its Jury Services staff to provide copies of the Los Angeles County Civil Grand Jury 2001-2002 final report, and each subsequent Civil Grand Jury final report to all Los Angeles County Superior Court juror assembly rooms to help educate the public and recruit other interested volunteers.

5. The Edit Committee recommends that the Board of Supervisors work with the Superior Court to continue and improve its educational outreach program, utilizing as many forms of media broadcasting as possible, in an attempt to recruit Civil Grand Jurors from the rich and diverse racial/ethnic population that encompasses the County of Los Angeles.

EDUCATION COMMITTEE

LOTTERY MONEY FUNDS
REVENUES AND EXPENDITURES AUDIT

BACKGROUND

The Education Committee of the Los Angeles County Civil Grand Jury 2001-2002 contracted with an independent auditor to review the Los Angeles Unified School District (LAUSD) with regard to its expenditure of restricted state lottery monies.

On November 6, 1984, 58% of California voters approved Proposition 37 entitled "The California State Lottery Act" (CSLA). The act provides that at least 34% of the Lottery Revenues must go to public education. This supplemental funding provides additional resources to meet their locally determined needs.

OBJECTIVE

The Lottery's mandate in the California State Lottery Act (SCLA) is to provide supplemental funding to California Public Education on all levels from kindergarten through the universities of California, plus several specialized schools. According to the Lottery Act, lottery contributions can be used only for instructional purposes and it bans use for the acquisition of property, the construction of facilities, or the funding of research. Approximately 80-90% of the California lottery funds are to be used to attract and retain teachers.

The Education Committee of the Los Angeles County Civil Grand Jury 2001-2002 determined to review revenues and expenditures of the LAUSD. The following report represents the findings and recommendations based on information gathered from this limited scope management audit.

EDUCATION COMMITTEE

BACKGROUND AND OBJECTIVES

The California State Lottery Act of 1984 was enacted to supplement the total amount of money allocated for public education in California. Government Code Section 8880.4 provides for the allocation of Lottery revenues and requires that at least 34 percent of the total annual revenues of the State Lottery be allocated to the benefit of public education. Government Code Section 8880.5 restricts the use of these funds exclusively for the education of pupils and students and prohibits the expenditure of funds for the acquisition of real property, construction of facilities, financing or research, or any other non-instructional purpose. Since its enactment, the Los Angeles Unified School District (LAUSD) has received approximately $1.3 billion to supplement existing educational funding sources available to the District.

In March 2000, Proposition 20 known as the "Cardenas Textbook Act of 2000" was approved by the voters. This proposition amended Section 8880.4 of the Government Code effective July 1, 1998 by placing further restrictions on the use of lottery monies and allocating future increases in lottery proceeds as follows. Beginning in fiscal year 1998-99 and each fiscal year thereafter, 50 percent of any growth in lottery funds allocated for educational purposes over the 1997-98 base fiscal year shall be allocated to school districts for the purchase of instructional materials on the basis of an equal amount per unit of average daily attendance. Government Code Section 8880.5 (l) requires as a condition of receiving such monies, each district and county superintendent of schools shall establish a separate account for the receipt and expenditure of the monies and such account shall be identified as a lottery education account.

In order to determine if the Los Angeles Unified School District (LAUSD) has complied with the expenditure and accounting restrictions placed on State Lottery educational funds, the Grand Jury authorized a limited scope management audit. The audit focused on State Lottery receipts and expenditures for FY 1998-99, FY 1999-00, and FY 2000-01. In addition, the audit compared actual receipts and reported expenditures to determine the unexpended balance of restricted lottery monies as of June 30, 2001.

METHODOLOGY

The audit of LAUSD compliance with State Government Code restrictions on the expenditure of and accounting for State lottery monies included the following audit procedures.

- An entrance conference was held with LAUSD officials on January 16, 2002 to explain the purpose, objective, scope and procedures of the management audit process.

- Interviews were conducted with the District Controller, Budget Officer, Chief Accountant and other District staff responsible for the accounting and budgeting of State lottery monies.

- District financial, accounting, and budget reports, as well as audited financial statements for the last three fiscal years were obtained and analyzed. To determine the correct fund balance as of June 30, 2001, reports to the State Department of Education for FY 1985-86 through FY 2000-01 were obtained and analyzed.

- A special electronic data processing report was prepared by District staff listing each detailed transaction charged against restricted lottery monies available for instructional materials only. This report identified $18.4 million of expenditures reported to the State of California Department of Education for FY 2000-01. This report was analyzed to determine if the purpose of the detailed transactions complied with the restricted uses permitted by State law. In addition, a systematic random sample of 100 transactions was selected to determine if the reported classification of expenditures on the electronic report was consistent with the purpose shown on the actual invoices and other documentation.

FINDINGS

Analysis of Lottery Revenues

The LAUSD received a total of $1,303,052,279 in lottery monies since the enactment of the 1984 California State Lottery Act. This amount includes $1,284,584,904 of public education monies and $18,467,375 of instructional materials monies. The LAUSD deposits lottery revenues in its General Fund. No separate accounting for expenditures is done for the lottery public education monies since these revenues are commingled with all other General Fund revenues. However, lottery monies that are restricted for instructional materials purchases only are accounted for separately through the use of an accounting system program code designated as "Program 4153 Lottery Instructional Materials." These lottery revenues are shown below by fiscal year.

Table 1
LAUSD California State Lottery Revenue by Fiscal Year

Fiscal Year	Public Education Revenue	Instructional Materials Revenue
1985-86	$ 73,274,879	
1986-87	60,644,902	
1987-88	83,412,011	
1988-89	118,950,974	
1989-90	96,859,361	
1990-91	78,402,821	
1991-92	55,158,009	
1992-93	60,584,287	
1993-94	65,752,018	

1994-95	79,406,706	
1995-96	84,375,503	
1996-97	75,482,331	
1997-98	84,218,994	
1998-99	88,987,003	
1999-00	89,397,948	$ 4,503,504
2000-01	89,677,157	13,963,871
Total	**$1,284,584,904**	**$18,467,375**

Analysis of Lottery Expenditures

Based on an analysis of J-200L annual reports filed with the State Department of Education, the LAUSD had a reported fund balance of unexpended public education lottery monies amounting to $66,514 as of June 30, 2001. The unexpended fund balance of instructional materials lottery monies amounted to $67,173 as of June 30, 2001. These reported balances are shown in the following table.

Table 2
LAUSD California State Lottery Expenditures by Fiscal Year

Fiscal Year	Public Education Expenditures	June 30 Unexpended Balance	Instructional Materials Expenditures	June 30 Unexpended Balance
1985-86	$ 0	$73,274,879		
1986-87	116,007,995	17,911,786		
1987-88	61,524,635	39,799,162		
1988-89	139,060,103	19,690,033		
1989-90	115,878,925	670,469		
1990-91	79,073,290	0		
1991-92	55,158,009	0		
1992-93	57,184,287	3,400,000		
1993-94	69,152,018	0		
1994-95	69,459,359	9,947,347		
1995-96	79,413,533	14,909,317		
1996-97	80,968,041	9,423,607		
1997-98	80,873,106	12,769,495		
1998-99	101,756,497	1		
1999-00	89,397,948	1	0	4,503,504
2000-01	89,745,441	66,514	18,400,562	67,173
Total	**$1,284,585,203**		**$18,400,562**	

LAUSD accounting records also show that the expenditure of lottery monies restricted for instructional materials based on average daily attendance in each of the 11 local districts ranged from a low of $23.63 to $28.22 per student as shown in Table 3. It should be noted that these

expenditures reflect approximately one and one-half years of funding of instructional materials monies for the 11 local districts and only one year of funding for the financially independent charter schools. Exhibit 1 describes the geographic location of each local district and reports enrollment by grade level for FY 2000-01.

Table 3
Analysis of FY 2000-01 Lottery Expenditures for Instructional Materials By Local District

Local District	Instructional Materials Expenditures	Average Daily Attendance	Average Expenditure Per Student
C	$1,901,204	67,381	$28.22
J	1,743,671	64,309	27.11
A	1,893,495	70,691	26.79
K	1,785,561	66,888	26.69
D	1,472,891	57,238	25.73
G	1,515,022	59,205	25.59
H	1,717,491	69,351	24.77
I	1,309,221	53,509	24.47
F	1,486,370	61,514	24.16
B	1,872,683	77,614	24.13
E	1,611,567	68,196	23.63
Charter Schools	67,984	4,676	14.54

Although Table 3 shows that the average amount of lottery instructional materials funds expended per student varied by as much as 19 percent between local districts, more importantly, LAUSD accounting records show that the District significantly increased total expenditures for instructional materials during the most recent three fiscal years. In FY 1999-00, total expenditures for instructional materials increased by $41 million from $68.1 million to $109.1 million over the prior fiscal year. In FY 2000-01, total expenditures for instructional materials again increased by $58.7 million from $109.1 million to $167.8 million over FY1999-00. For the three-year period, total expenditures for instructional materials increased by 146 percent. Expenditures per student by the fiscally independent charter schools of lottery monies restricted for instructional materials amounted to only $14.54 per student. This rate of expenditure is not comparable to the rates shown in Table 3 for the 11 local districts, since it is based on only one year of funding versus approximately one and one-half years of funding for the 11 local district schools.

However, analysis of J-200L annual reports filed with the State Department of Education, also determined that certain expenditures made from public education monies and from instructional materials monies did not comply with the restrictive uses of such monies as required by Government Code Section 8880.4. Exhibit 2 is a copy of the FY 2000-01 annual report to the

State, which clearly identifies prohibited expenditures for capital outlay purposes. These prohibited expenditures are shown as italicized figures in Table 4.

Table 4
Detail of LAUSD California State Lottery Expenditures as a result of Object Code

Fiscal Year	Personnel Mat & Sup	Services & Other Oper	Capital	Other Outgo
1985-86	$ 0	$ 0	$ 0	$ 0
1986-87	92,538,705	853,929	960,604	12,030,000
1987-88	57,461,349	500151	0	0
1988-89	135,021,073	795,595	0	0
1989-90	112,817,258	809,666	0	0
1990-91	78,863,672	62,633	0	0
1991-92	54,959,975	187,736	0	0
1992-93	57,150,462	33,825	0	0
1993-94	69,112,501	38,167	0	0
1994-95	69,389,072	68,498	0	0
1995-96	79,317,326	79,576	0	0
1996-97	80,822,520	130,828	0	0
1997-98	80,787,750	50,859	0	0
1998-99	101,659,801	88,032	0	0
1999-00	89,382,043	6,044	0	0
2000-01	85,851,448*	2,383,980	1,510,013	0
Total	**$1,284,585,203**	**$6,089,519**	**$2,470,617**	**$12,030,000**

* $10,437,729 of this amount was expended for various supplies and services from the restricted instructional materials monies.

Table 4 identifies expenditures in FY 1986-87 and FY 2000-01 that were not permitted from the two restricted lottery funding sources. Unallowable expenditures from lottery public education monies during FY 1986-87 and FY 2000-01 totaled $27,321,832. Unallowable expenditures of restricted lottery instructional materials monies accounted for $14,331,228 of the $18,400,375 expended in FY 2000-01, the first fiscal year in which these new restricted lottery monies were available for expenditure. It should be noted that charter schools accounted for $67,984 of the $18,400,375 expended from restricted lottery instructional materials. However, because charter schools are responsible for and conduct all of their own accounting functions, including accounting for restricted lottery monies, the LAUSD does not monitor or audit lottery expenditures reported by the charter schools to the LAUSD for inclusion in its annual report to

the State. As a result, LAUSD has no way of determining if the charter schools, which obtain lottery monies through the sponsorship of LAUSD, are expending such funds in compliance with State law. Accordingly, LAUSD should develop procedures to obtain adequate supporting documentation from charter schools to verify the appropriateness of charter school restricted expenditures as a sponsor responsibility.

In order to improve the budgetary presentation and to ensure future compliance regarding the expenditure of restricted lottery monies, several budget and accounting procedural changes are recommended to simplify and clarify the day-to-day processes pertaining to these funds.

Proposed Revision of Procedures for the Budgeting and Accounting for Restricted Lottery Monies

The LAUSD budget process does not currently include any specific procedures relative to the budgeting of restricted lottery monies, either at the local district level or on a District-wide basis. Although governed by State law requiring a specific budget hearing and board resolution, limited as to the permissible uses of such funds and encumbered by special accounting and reporting requirements, LAUSD has not developed any written procedures to ensure compliance with these mandates. Clearly, such procedures would be useful to facilitate the consistent and thorough budget process intended by the Legislature to ensure adequate budgeting of monies for textbooks and instructional materials.

The current LAUSD budget process also does not separately account for the restricted lottery monies. Both the public education funds and the instructional materials funds are included as General Fund revenues and are not separately identified by object of expense or local district within the LAUSD annual budget. Although the accounting system includes separate program categories for each of these restricted revenue sources, any object of expense such as salaries, benefits, equipment, capital improvements and others can be charged to any program category. As a result, actual accounting practices have not consistently followed the intended restrictions envisioned by the assigned program categories for lottery monies.

To minimize the possibility of coding inappropriate charges to these restricted funding sources in the future, separate funds should be established for each of the restricted lottery revenues and monies expended in prior years for non-compliant purposes should be deposited in these funds from the General Fund unreserved and undesignated fund balance. In addition, the annual LAUSD budget should appropriately reflect the use of these restricted funds in the local district budgets for purposes consistent with the permitted uses. The clear designation of restricted instructional materials funds in the budget would be consistent with the requirement of Education Code Section 60119, which requires each district receiving such monies to conduct a public hearing as to the adequacy of funding for textbooks and other instructional materials and for the local board of education to adopt a resolution certifying such adequacy.

Proposed Amendment of Education Code Section 8880.4

Given the compliance issues experienced by LAUSD in properly executing and accounting for expenditures of restricted lottery monies, and considering the clear intent of the Legislature to mandate a set of requirements designed to ensure supplemental funding for instructional materials pursuant to the to "Cardenas Textbook Act of 2000," additional amendments to Education Code Section 8880.4 would be appropriate. Because Education Code Section 8880.4 currently does not require the establishment of a separate fund to account for revenues and expenditures of restricted lottery monies and does not include a maintenance of effort requirement to ensure enhanced levels of on-going funding for instructional materials, such provisions are needed to carry-out the legislative intent of the Cardenas Textbook Act of 2000. Therefore, the Los Angeles County Board of Supervisors should seek to have the Legislature amend Government Code Section 8880.4 to require local educational agencies to establish special funds for the receipt and expenditure of lottery educational and instructional material monies to ensure the use of such funds in accordance with the intent of State law. Further, a maintenance of effort requirement based on FY 1997-98 expenditure levels per ADA (average daily attendance) should be established and annually adjusted in accordance with annual changes in the consumer price index, to ensure local educational agencies do not supplant existing funding sources with lottery funding intended for instructional materials only.

Education Committee

LAUSD EXPENDITURE OF RESTRICTED STATE LOTTERY MONIES
RECOMMENDATIONS/SOLUTIONS

The Education Committee recommends that the LAUSD:

6. Establish separate funds for the receipt and expenditure of Lottery Monies in order to ensure that such funds are expended in accordance with the restricted purposes specified by State law.

7. Develop written procedures to specify appropriate budgeting, expenditure, and public hearing processes as described in Government Code Section 8880.4 and Education Code Section 60119.

8. Transfer approximately $14.3 million of General Fund monies to the Lottery Instructional Materials Special Fund to account for prior year expenditures not in compliance with Government Code Section 8880.4 restrictions.

9. Transfer approximately $13.0 million of General Fund monies to the Lottery Educational Special Fund to account for prior year expenditures not in compliance with Government Code Section 8880.4 restrictions.

10. Establish procedures to monitor the expenditure of lottery monies allocated to charter schools to ensure that such expenditures are in accordance with the restrictions of State law.

The Education Committee recommends that the Los Angeles County Board of Supervisors should urge the State Legislature to:

11. Amend Government Code Section 8880.4 to require local educational agencies to establish special funds for the receipt and expenditure of lottery educational and instructional material monies to ensure the use of such funds in accordance with the intent of State law. Further, a maintenance of effort requirement based on FY 1997-98 expenditure levels per ADA (average daily attendance) should be established and annually adjusted in accordance with annual changes in the consumer price index, to ensure local educational agencies do not supplant existing funding sources.

GOVERNMENT OPERATIONS COMMITTEE

Electronic Voting Machines

BACKGROUND

Many areas in the United States conduct their voting activities by using a punch-card ballot system. In the County of Los Angeles, the voting apparatus has consisted of a flat metallic box-like structure with a narrow slit along one end into which a cardboard voting slip is inserted. The card is printed with a rectangular area on one side filled with squares, in vertical and horizontal rows. In the center of each square is a small rectangular area delineated by an incompletely perforated border. Attached to the metal box is a small punch with a narrow end. In voting, the voter applies this punch to the area surrounded by the semi-perforation. This portion of the card (called a "chad") is punched free when a vote is recorded and falls into a shallow container on the bottom of the voting apparatus leaving a small hole in the voting card.

A voting booklet is attached to the voting device directly over the pocket into which the voting card is slipped. This booklet contains the names of candidates and the options on propositions and proposed legal changes. Each page of the booklet contains a vertical list of the candidates for a specific office, or the options for a specific proposition. Aligned to the right of each list is a vertical row of holes in the booklet's page. A person votes by using the attached punch to make a hole in the voting card through the hole in the booklet's page adjacent to the name of the candidate of the voter's choice. The vertical holes in the pages of the booklet cover a specific vertical row of squares on the voting card. Turning the page in the booklet presents a new list of candidates for a different office, and a new row of vertical holes. The vertical rows of holes in the pages of the booklet move across the voting card beneath to present a new area of the card for each change of page in the booklet. That is, for each different office or proposition being voted on, a different vertical row of squares on the voting card will be punched. At the end of voting one has a card with several vertical rows of squares with and without holes punched in them.

The size of the booklet depends on the number of offices and propositions being voted on and will vary from district to district. The characteristics of a voting area, its ethnic and national background and the language characteristics of its people, determine the number of languages in which the booklet must be printed. In 1984 the California electorate, by a large majority, passed Proposition 38, mandating the elimination of multilingual ballots. It was the general public's opinion, in California, that United States born citizens of voting age should be expected to be competent in the English language, and that naturalized citizens, in becoming naturalized, would be required to demonstrate a reasonable competence in the English language. In voting matters, however, Federal regulations take precedence. If there are 10,000 or more of a particular language group within a district, instruction booklets must be made available in that particular

language. In Los Angeles County in the last election, pre-election instruction booklets were necessary in seven different languages. The booklet attached to the voting machine was only in English.

When finished voting, a person withdraws the voting card from the voting device and places it in a large ballot box, which also holds the ballots from other voters in that polling place. At the end of the day's voting these cards are collected from the polling areas and transferred to a central location. Here they are fed into a tabulator where the numerical vote is determined by a scanner, which reads the various holes that have been punched in each card.

Under this system, to vote, all a person must be able to do is: (1) to read the booklet regarding candidates and office, or the propositions by name and number, (2) to turn the pages and (3) to make a hole in the voting card with the attached punch.

In the last Presidential election many counties in the State of Florida also used a punch-card form of equipment for voting. After the votes were collected, but while the votes were being counted, several complaints surfaced. The Florida system used what was called a "butterfly" ballot. The line of holes to be punched was not along a single line of choices. Rather, it was between two vertical lists of candidates, with some misalignment between the candidates' names and the holes to be punched in the pages. It was claimed that there was some confusion as to which hole should be punched for which candidate. This led to complaints that some voters had misread the ballot and mistakenly voted for the wrong candidate. It was certainly a complaint that could not be verified, nor corrected, if verified, after the ballots had been gathered together and run through the counting scanner.

Then there was the "chad" problem. As more people vote, there is a build-up in the number of paper chads in the collection box. If this chamber is not periodically emptied, the build-up of the paper chads will impair the action of the punch. The chad may not be punched completely free, leaving a "hanging chad" of varying degrees of separation from the card. As the chamber eventually fills, it may become impossible for the punch to free the chad at all, leaving only a "dimple" in the voting card. If the punch does not leave an adequate hole for the scanner to identify, the counting machine will not register a vote. In Florida, the counting machines did not register a vote for some candidates on some of the ballots. Critics claimed that the "no vote" ballots were incorrectly registered. It was claimed that by not counting these ballots, voting authorities had deprived people of their right to vote. The authorities attempted to solve the problem of missing votes by a hand count of the ballots rejected by the scanner as "not voting." Obviously, the original voter of such a particular ballot could not be identified. The officials doing the hand count tried to decide if hanging chads and dimples were really uncounted attempts to vote. There was much debate and effort expended in this hand counting of the machine-discarded ballots, especially in trying to determine if a "dimpled" ballot really represented an unsuccessful attempt by the voter to vote. People doing the counting frequently

disagreed on the interpretation of the same ballot. In many cases there was controversy over whether or not a particular ballot was "dimpled."

Consequently, the punch-card system, itself, was criticized.

The problems in Florida were not present in California. In California there was no butterfly ballot. In the voting booklet there was a single page for each office, one list of candidates per row of punch holes, one list per page, and no margin for misunderstanding. The names of the candidates were aligned with the row of holes to be punched. The collection boxes were regularly emptied. Hence, no chads, hanging or otherwise, interfered with "punching a hole." There was no confusion of "dimples" as an uncounted but intended vote, as punching regularly produced a hole, which was counted by the scanning machine. Voting and counting appeared to be straightforward. Mail in ballots are of the punch-card variety, using a single card with the various squares in which holes are to be punched. Such cards are counted in the same manner as the cards collected from the voting booths.

Because of the national furor, the Secretary of the State of California, in 2001, decertified the punch-card voting equipment, indicating that the equipment was to be replaced as soon as possible. In February 2002, the Federal government was more specific and ruled that the equipment must be replaced in time for the 2004 elections.

OBJECTIVE

The objective of the Government Operations Committee was to evaluate the proposed electronic voting machines and to compare them with the recently used voting devices.

METHODOLOGY

The Committee visited the offices of the Registrar of Voters to examine models of the proposed electronic voting machines. Voting officials were available to discuss their plans. Management and engineering personnel presented the equipment and discussed designs of the current first generation model and proposals concerning future designs to the fourth generation models currently on the drawing boards. Use of the current model was explained, and the Committee participated in a hands-on practice of voting using the demonstration model. Details of the possible variations in its structure, the flexibility in its operation, the possibilities of its

malfunctioning, and the chance of its being sabotaged, were studied. Pertinent comparisons between the old and the new systems were made.

FINDINGS

The first generation electronic model voting machine was both large and heavy. It resembled, somewhat, a small microwave oven with the voting surface on the top appearing like the front of a desktop computer. The "voting booklet" was programmed into the machine as software. Visible directions were projected on the face of the machine through the programming system. The print of the projected instructions was sufficiently large to make reading easy. The voter "turned pages" by touching the proper area of the surface. One voted by touching the area indicated for the particular candidate. This touch registered on the face of the machine and also on an internal counter. Correcting a voting error was performed by touching a "change" or "error" button. The voter could review previous "pages" and correct votes in a simple way.

When finished and satisfied, the voter so indicated by the proper touch. It was then that the internal counting was recorded. The machine accumulated the voting done on it, so that the count on each machine was completed when the voting day was done. At the close of voting it was possible for each machine's count to be transmitted by wire to a central area and combined electronically with the counts from the machines of many other areas. Under most circumstances the speed of counting was a great improvement over prior voting systems. Very little "manpower" was needed in counting. The equipment software could be programmed and reprogrammed to satisfy the variations in candidates and election questions from one district to another and from one election to another. Language variations could be handled in a similar fashion, by an operator's appropriately programming the software.

It appeared possible that absentee electronic voting might be managed through personal computers and/or through the Internet.

On the other hand, voting by simple mail-in ballots was not amenable to this system. Mail-in voting would require another system, such as the prior used punch-card ballot.

The difference in the cost of the necessary software and its periodic reprogramming, from the cost of printing and distributing multiple voting card forms, was not determined; but the Committee estimated that the difference was not a significant factor in the evaluation of the two systems. The varieties of the pre-election instruction booklet would be the same for the two systems. The operation of the electronic machine once programmed, versus the handling and collecting of voting cards during voting, would probably be a plus for the new equipment.

Voting for a write-in candidate on the electronic machine was as easy as voting for a write-in candidate on the punch-card.

The size and weight of the latest model electronic machine were marked disadvantages compared to similar features of the machine. Polling places have been staffed, in large part, by elderly retired people. Moving the available electronic machines around, before and after voting hours, could be a difficult task for such people. While the projection for future models of the electronic device suggests a thin, lightweight laptop computer-sized instrument, this development has not yet materialized.

The equipment was used in selected locations in elections in 2000 and 2001. The public reaction was positive and voter confusion appeared minimal. Programming election and candidate variations and allowing write-in choices were easily implemented by the equipment software. A large mass of voting cards, their storage and counting were not necessary. Computerized counting took place during voting.

The Registrar of Voters was considering increasing the size of the current local voting areas. There would be fewer but more centrally positioned voting centers in common gathering places such as shopping malls. It was conjectured that such voting areas with fewer electronic machines could accommodate larger numbers of voters in shorter times, thus reducing equipment and manpower costs. Not too much consideration, here, however, has been given to the fact that such fewer stations would increase the average distance for a voter to travel to vote, and would provide greater travel problems for the elderly and those without personal means of transportation. Preferred parking for voters and politically provided transportation were considered as ways to improve this situation.

The cost of the electronic voting machine, then about $5,000 each, was expected to decrease to about $1,000 as its design and engineering improved. With about 5000 voting areas in the Los Angeles County and an average of 4 devices per polling station, the County would need about 20,000 of the new machines, at a cost of at least $20,000,000. These electronic devices would be expected to have shorter functional lives and higher repair costs than the current equipment. Proposition 41 on the March 2002, ballot requested voter approval for the State of California to spend money on these machines. The amount requested included $67,000,000, the estimated cost for the purchase and upkeep of the electronic voting machines needed in just Los Angeles County. (Addendum: On March 5, 2002, California voters passed Proposition 41, the Voting Modernization Act of 2002, by a vote of 2,229,531 to 2,103,265, authorizing a bond issue of $200,000,000.00, to purchase and maintain new voting machines. The cost of the punch-card machines has long since been amortized. The repair and servicing requirements for the punch-card equipment are minimal.

The Government Operations Committee of the 2001-2002 Los Angeles County Civil Grand Jury questioned if enough consideration had been given, by the designers of the electronic voting machine, to the system's integrity and security during the voting process and during storage. There is a potential for sabotage and malicious interference in our society that the Committee felt should be recognized. Care should be taken to minimize this danger. Electrical problems such as a local power outage, a surge or a disruption of any kind could affect any electronic equipment

then in use. Prolonged outages could delay voting. Transmission line problems could delay the transfer of data to centralized areas. An individual in, or near, the voting area, with a small container holding specialized electronic equipment, might be able to affect the operation of the voting machines during their use.

The function of the machines might also be disturbed before voting started, while the machines were in storage. The voting results themselves appeared vulnerable. They could be corrupted through the electronic processes involved in voting, disrupting the "ballot" presentation process, through the storage and counting mechanisms or during the transmission of the voting data to central areas. Such data loss would be as permanent as the loss of bundles of "punched cards." Absentee ballots voted electronically would be still more difficult to protect. It is probable that the more anti-social individuals in our society would consider the technology of such machines as a tempting challenge, to see if the instrument could be functionally upset, if the system could be made inoperable. Using an Electromagnetic Pulse Device, (EMP), such people could cause a near instantaneous and totally disruptive effect on the operations of the voting machines, particularly on the tapes, the disks, adjacent circuits and other storage systems, if these elements were not properly shielded and protected. The United States House of Representatives' American Services Committee report, HASC 106.31, October, 1999, titled EMP Threats to U. S. Military and Civil Infrastructure describes such threats. In cases of electronic absentee voting, such interference by malicious people would be even more difficult to prevent.

It was while this study was being finalized, February 2002, that the Federal Government mandated the elimination of the punch-card system. This Committee feels the mandate may have been a bit premature. Except for the Florida problem, the punch-card system has been used successfully for many years. It seems possible, if not probable, that in Florida, the difficulty with the system was an inappropriate application of the system, rather than the system itself. While the electronic voting machine offers much promise, it is currently bulky and heavy and still far too expensive. It's susceptibility to interference and sabotage needs further testing. While improved machines are being developed, they should continue to be tested regarding their acceptance by the public, their accuracy, their cost and their safety from interference. If advanced models test satisfactorily and continue to compare equal to or better than the punch-card system, then the latter system could be eliminated.

Everyone concerned should always remember the age-old adage, "If it ain't broke, don't fix it!" Especially, don't, if it's going to cost a lot of money that isn't available!

Government Operations Committee

ELECTRONIC VOTING MACHINES
RECOMMENDATIONS

12. The Government Operations Committee recommends that the Board of Supervisors should urge the Los Angeles County Registrar of Voters to evaluate more extensively the electronic voting machine, during voting, especially as to its acceptability by the voting public, the ease with which it is moved and handled, its vulnerability to functional disruption accidentally or through intentional sabotage, and the accuracy with which it seems to operate.

13. The Government Operations Committee recommends that the Board of Supervisors should urge the United States Congressmen representing districts in the County of Los Angeles to urge the Federal Government to rescind the mandate preventing the use of punch-card voting techniques, until such time as a suitably constructed and adequately protected electronic voting machine has been satisfactorily tested.

14. The Government Operations Committee recommends that the Board of Supervisors should request from the Federal Government sufficient financing to cover the additional cost that the County of Los Angeles will incur if forced to adopt a new voting machine system before protection for the system has been provided, especially if the new machine involved must be adopted before the machine itself has been completely tested and proven.

15. The Government Operations Committee recommends that the Board of Supervisors should direct the County Registrar of Voters not to enlarge the area of voting districts without improving accommodations at and transportation to the new polling places.

GOVERNMENT OPERATIONS COMMITEE

Los Angeles County Commissions

BACKGROUND

The Los Angeles County Civil Grand Jury is charged with the oversight responsibility for Los Angeles County government and of the governing bodies of the cities and special districts located within Los Angeles County.

Los Angeles County has a number of commissions comprised of individuals (commissioners) officially appointed by the Board of Supervisors to perform specific duties with quasi-judicial quasi-legislative powers.

Much information has been obtained by the Commissions. Ready access to this information would be of great value and assistance to various committees of the civil Grand Jury. A list of the Commissions and how they could be reached would provide such an access.

OBJECTIVE

The objective of the Government Operations Committee of the Los Angeles County Civil Grand Jury 2001-2002 was to compile a list of the functioning commissions of Los Angeles County, including their current mailing addresses and telephone numbers. This list would be made available for the use of all future Civil Grand Juries of Los Angeles County.

FINDINGS

Updates to the list are provided periodically to the Los Angeles County Civil Grand Jury and are filed in a binder listing the Commissions and Committees. Portions of the information from the list provided to the Civil Grand Jury were not always available to the Civil Grand Jurors, either because the information for some reason was never provided, or because it had been removed and not returned.

The information available from the various commissions can be extremely valuable to the various committees of the Civil Grand Jury. Currently there is no definitive area for the Los Angeles County Civil Grand Jury to keep a library of important reference material.

Government Operations Committee

LOS ANGELES COUNTY COMMISSIONS REPORT -

RECOMMENDATIONS

16. The Government Operations Committee recommends that the Los Angeles County Civil Grand Jury should maintain the established library of important Civil Grand Jury reference documents and reports.

17. The Government Operations Committee recommends that subsequent Los Angeles County Civil Grand Juries should place in the permanent library file the list of Los Angeles County Commissions compiled by the Government Operations Committee of the 2001-2002 Civil Grand Jury.

18. The Government Operations Committee recommends that subsequent Los Angeles County Civil Grand Juries should review this list of Los Angeles County Commissions annually and update it as necessary.

LOS ANGELES COUNTY COMMISSIONS

Alphabetical Listing

Aging	Los Angeles County Commission on Aging
Agriculture	Agricultural Commissioner, Department of Weights and Measures
Alcoholism	Commission on Alcoholism
Arts	Los Angeles County Arts Commission
Aviation	Aviation Commission, Department of Public Works
Beach	Los Angeles County Beach Commission
Business License	Business License Commission
Cerritos Regional County Park	Cerritos Regional County Park Authority Commission
Children and Families	Commission for Children and Families
Children and Families-First-Proposition 10	Los Angeles County Children and Families First-Proposition 10 Commission
Citizens' Economy and Efficiency	Los Angeles County Citizens' Economy and Efficiency Commission
Civil Service	Civil Service Commission
Community Development	Community Development Commission Board of Commissioners
Disabilities	Los Angeles County Commission on Disabilities
Emergency Medical Services	Emergency Medical Services Commission
Emergency Preparedness	Emergency Preparedness Commission for the County and Cities of Los Angeles
Employee Relations	Employee Relations Commission
Fish and Game	Fish and Game Commission
Health Facility	Los Angeles County Health Facilities Authority Commission
Highway Safety	Los Angeles Highway Safety Commission
Historical Landmarks	Los Angeles County Historical Landmarks and Records Commission
HIV Health Services	Commission on HIV Health Services
Hospital and Health Care Delivery	Hospitals and Health Care Delivery Commission
Housing Authority	Housing Authority Board of Commissioners
Human Relations	Commission on Human Relations
Information Systems	Information Systems Commission
Institutional Inspections	Sybil Brand Commission for Institutional Inspections
Insurance	Los Angeles County Commission on Insurance
Judicial Procedures	Commission on Judicial Procedures
Library	Library Commission
Local Agency Formation	Local Agency Formation Commission
Local Government Service	Los Angeles County Commission on Local Government Services

Los Angeles Convention and Exhibition Center	Los Angeles County Convention and Exhibition Center Authority Commission
Los Angeles County Downey Regional Public Recreational Area	Los Angeles County Downey Regional Public Recreation Area Commission
Los Angeles County Martin Luther King Jr. General Hospital	Los Angeles County Martin Luther King Jr. General Hospital Authority Commission
Memorial Coliseum	Los Angeles Memorial Coliseum Commission
Mental Health	Los Angeles County Mental Health Commission
Milk	Los Angeles County Milk Commission
Narcotics and Dangerous Drugs	Narcotic and Dangerous Drugs Commission
Native American Indian	Los Angeles City/County Native American Indian Commission
Parks and Recreation	Parks and Recreation Commission
Probation	Probation Commission
Public Health	Public Health Commission
Public Social Services	Commission for Public Social Services
Quality and Productivity	Quality and Productivity Commission
Real Estate Management	Real Estate Management Commission
Regional Planning	Regional Planning Commission
Small Business	Los Angeles County Small Business Commission
Solid Waste Authority	Los Angeles Solid Waste Authority Commission
Sybil Brand Institutional Inspection	Sybil Brand Commission for Institutional Inspection
Veterans Advisory	Los Angeles County Veterans Advisory Commission
Women	Commission for Women

Contact Information

Agricultural Commission
Department of Weights and Measures
12300 Lower Azusa Road
Arcadia, 91006
626-575-5471
626-575-5453

Aviation Commission
Department of Public Works
Aviation Division
900 South Fremont Avenue
Alhambra, 91803-1331
626-458-7389

Business License Commission
500 West Temple Street, Room 379
Los Angeles, 90012
213-974-7691

Cerritos Regional County Park Authority Commission
500 West Temple Street, Room 383
Los Angeles, 90012
213-974-1403

Civil Service Commission
222 North Grand Avenue, Room 522
Los Angeles, 90012
213-974-2411

Commission for Children and Families
500 West Temple Street, Room B-22
Los Angeles, 90012
213-974-1558

Commission for Public Social Services
12860 Crossroads Parkway South
City of Industry, 91746
562-908-8669

Commission for Women
500 West Temple Street, Room 383
Los Angeles, 90012
213-974-1403

Commission on Alcoholism
1000 South Fremont Avenue
Alhambra, 91803-4737
626-298-4106

Commission on HIV Health Services
600 South Commonwealth Avenue, 6th Floor
Los Angeles, 90005
213-351-8127

Commission on Human Relations
320 West Temple Street, Room 1184
Los Angeles, 90012
213-974-7601

Commission on Judicial Proceedings
500 West Temple Street, Room 383
Los Angeles, 90012
213- 974- 1403

Community Development Commission
Board of Commissioners
2 Coral Circle
Monterey Park, 91755-7425
213-890-7001

Consumer Affairs Advisory Commission
500 West Temple Street, Room B-96
Los Angeles, 90012
213- 974-9750

Emergency Medical Services Commission
5555 Ferguson Drive, Suite 220
Commerce, 90022
323-890-7545

Emergency Preparedness Commission for the County and Cities of Los Angeles
1275 North Eastern Avenue
Los Angeles, 90063
323-980-2266

Employee Relations Commission
500 West Temple Street, Room 374
Los Angeles, 90012
213-974-2417

Fish and Game Commission
500 West Temple Street, Room 383
Los Angeles, 90012
213 974-1403

Hospitals and Health Care Delivery Commission
313 North Figueroa Street, Room 903
Los Angeles, 90012
213-240-7731

Housing Authority Board of Commissioners
2 Coral Circle
Monterey Park, 91755-7425
213-890-7001

Information Systems Commission
500 West Temple Street, Room 383
Los Angeles, 90012
213-974-1431

Library Commission
7400 East Imperial Highway, Room 201
Downey, 90241
562-940-8400

Local Agency Formation Commission
500 West Temple Street, Room 383
Los Angeles, 90012
213-974-1448

Los Angeles City-County Native American Indian Commission
3175 West 6th Street
Los Angeles, 90020
213- 351-5308

Los Angeles Convention and Exhibition Center Authority Commission
1201 South Figueroa Street
Los Angeles, 90015
213-741-1151

Los Angeles County Arts Commission
500 West Temple Street, Room 374
Los Angeles, 90012
213-974-1343

Los Angeles County Beach Commission
13837 Fiji Way
Marina del Rey, 90292
310-305-9546

Los Angeles County Children and Families First--Proposition 10 Commission
333 South Beaudry, Suite 2100
Los Angeles, 90017
213-482-5902

Los Angeles County Citizens' Economy and Efficiency Commission
500 West Temple Street, Room 163
Los Angeles, 90012
213-974-1491

Los Angeles County Commission on Aging
3333 Wilshire Boulevard, Suite 400
Los Angeles, 90010
213-738-2947

Los Angeles County Commission on Disabilities
500 West Temple Street, Room 383
Los Angeles, 90012
213-974-1403

Los Angeles County Commission on Insurance
500 West Temple Street Room 383
Los Angeles, 90012
213-974-1403

Los Angeles County Commission on Local Government Services
500 West Temple Street, Room 383
Los Angeles, 90012
213-974-1403

Los Angeles County Health Facilities Authority Commission
500 West Temple Street, Room 383
Los Angles, 90012
213-974-1403

Los Angeles County Highway Safety Commission
900 South Fremont Avenue
Alhambra, 91803-1331
626-458-5822

Los Angeles County Historical Landmarks and Records Commission
500 West Temple Street, Room 383
Los Angeles, 90012
213-974-1431

Los Angeles County Housing Commission
2 Coral Circle
Monterey Park, 91755
323-850-7405

Los Angeles County Mental Health Commission
550 South Vermont Avenue, 12th Floor
Los Angeles, 90020
213-738-4772

Los Angeles County Milk Commission
2525 Corporate Place, Room 150
Monterey Park, 91754
323-881-4006

Los Angeles County Small Business Commission
707 Wilshire Boulevard, Suite 27
Los Angeles, 90017
213-430-5340

Los Angeles County Veteran's Advisory Commission
1816 South Figueroa Street, Suite 100
Los Angeles, 90015
213-744-4827

Los Angeles County Downey Regional Public Recreation Area Commission
Post Office Box 7016
Downey, 90241-7016
562-904-7280

Los Angeles County Martin Luther King, Jr., General Hospital Authority Commission
500 West Temple Street, Room 313
Los Angeles, 90012
213-974-1403

Los Angeles Memorial Museum Commission
3911 South Figueroa Street
Los Angeles, 90037
213-765-6711

Los Angeles Solid Waste Authority Commission
900 South Fremont Avenue
Alhambra, 91803
626-458-4014

Narcotics and Dangerous Drugs Commission
1000 South Fremont Avenue
Building A-9 East, 3rd Fl.
Alhambra, 91803-4737
626-299-4105

Parks and Recreation Commission
433 South Vermont Avenue
Los Angeles, 90020
213-738-2954

Probation Commission
9150 East Imperial Highway
Downey, 90242
562-940-3694

Public Health Commission
241 South Figueroa Street, Room 109
Los Angeles, 90012
213-240-8377

Quality and Productivity Commission
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 565
Los Angeles, 90012
213-974-1361

Real Estate Management Commission
222 South Hill Street, 3rd Floor
Los Angeles, 90012
213-974-4300

Regional Planning Commission
320 West Temple Street, Room 1390
Los Angeles, 90012
213-974-6409

Small Craft Harbor Commission
13837 Fiji Way
Marina del Rey, 90292
310-305-9522

Sybil Brand Commission for Industrial Inspection
500 West Temple Street, Room 372
Los Angeles, 90012
213-974-1465

LOS ANGELES COUNTY COMMITTEES

Audit

City Selection

Clean Fuel Program

Community Advisory

Countywide Criminal Justice Coordinator

Horizon's Plan

Independent Citizen's Oversight

Labor Management Advisory on Productivity Enhancement

Los Angeles County Hazardous Waste Management

Los Angeles County Solid Waste Management

Los Angeles County Street Naming

Policy Steering for South Bay Commuter Bus Service

Proposition E Special Tax

Risk Management Advisory

Savings Plan

Southern California Board of Trustees

Sunshine Canyon Landfill

Supervisory District Boundary Review

Technical Review

Traffic Reduction and Free Flow Inter are not

Treasury Oversight

HEALTH & HUMAN SERVICES COMMITTEE

Stroke Centers

BACKGROUND

As our population ages, the incidence of stroke increases. Disability and death due to stroke also increase and become a larger problem in health care. Various groups of the medical community have proposed that some hospitals set up stroke centers that would have specific stroke treatment protocols. They would have equipment and personnel immediately available to diagnose and treat stroke patients rapidly in a manner that would insure less deaths and less disability.

Successful treatment of stroke has an important time sensitive component. If proper diagnosis is not made and proper treatment is not instituted within a specific time frame, patients' outcomes suffer. Hospitals having proper personnel and equipment, as well as approved medications immediately available (the stroke center concept) would increase the likelihood of a better outcome for the patient.

Stroke centers were discussed in an article in the Journal of the American Medical Association (JAMA, June 21, 2000—Vol. 283 No. 23). The article established criteria for the institution and operation of stroke centers. Primary stroke centers would provide emergency care and stabilize acute stroke patients. Comprehensive stroke centers would provide more specialized care for the most complex problems.

Various specialists investigated stroke treatment, and their conclusion was that having specialized stroke centers would definitely improve the care of stroke patients. Interestingly, many hospitals surveyed felt they had staff and equipment to become primary stroke centers, but few actually fulfilled the criteria established in the JAMA article.

For example, tissue-type plasminogen activator (tPA) is considered the best treatment for a specific type of stroke. Nevertheless, it was found in a survey that only 1.8% of patients in Ohio and 2-3% in the nation with that type of stroke were treated with this medication.

OBJECTIVE

The Health and Human Services Committee objective was to promote the establishment of stroke centers in Los Angeles County.

METHODOLOGY

Various experts in the management and care of stroke victims were contacted, and materials related to stroke centers were reviewed. Specific geographical (catchment) areas and the politics of these areas were investigated.

FINDINGS

UCLA has published a study assessing physician attitudes and hospital resources in Southern California. Although some hospital personnel as well as physicians thought they were able to care for stroke victims in an acceptable manner, very few met the recommended criteria for stroke care.

In many studies, mortality and morbidity decreased when stroke center criteria were followed.

Trauma centers provide personnel and equipment that could be used in fulfilling stroke center criteria. The economic loss suffered by trauma centers could be partially offset by their adding stroke center services.

Establishment of stroke catchment areas is difficult because hospitals jealously guard their patient population.

CONCLUSIONS

Hospitals having stroke centers as part of the medical landscape of Southern California would probably save lives and prevent and lessen disabilities following strokes. The County through its hospitals would probably save money by decreasing the length of patient's hospital stays and the disabilities resulting from their strokes. Establishment of these centers is a daunting task. Work on this problem has been going on for some time.

Health & Human Services Committee

STROKE CENTERS

RECOMMENDATIONS

19. The Health & Human Services Committee recommends that the Department of Health Services should establish criteria for stroke centers that are compatible with American Medical Association guidelines.

20. The Health & Human Services Committee recommends that the Department of Health Services should add stroke centers to current trauma centers to address financing and to prevent duplication of personnel.

21. The Health & Human Services Committee recommends that the Department of Health Services should help settle catchment area controversies.

HEALTH & HUMAN SERVICES COMMITTEE

Abandonment of Newborns

BACKGROUND

Loss of life of babies abandoned in inappropriate places is a terrible tragedy. Mothers (and sometimes fathers) have babies or have custody of babies that they either do not want, or for whom they are unable to care. They make decisions under great emotional stress that may be poorly thought out resulting in bad choices that may lead to harm to the baby and harm to the parent(s).

The great distress of these parents has come to the attention of the California Legislature. In order to help prevent such tragedies in the future, the legislature has passed SB 1368 (California Penal Code 271.5).

> California Penal Code 271.5
>
> > (a) No parent or other person having lawful custody of a minor child 72 hours old or younger may be prosecuted for a violation of Section 270, 270.5, 271, or 271a if he or she voluntarily surrenders physical custody of the child to any employee, designated pursuant to this section, on duty at a public or private hospital emergency room or any additional location designated by the county board of supervisors by resolution. Each such hospital or other designated entity shall designate the classes of employees required to take custody of these children.
> >
> > (b) This section shall be repealed on January 1, 2006, unless a later enacted statute extends or deletes that date.

This law allows abandonment of a baby without legal penalty if, within the first 72 hours following birth of the baby it's physical custody is voluntarily surrendered to any employee on duty in any public or private hospital emergency room. This law became effective January 1, 2001. Although the County Board of Supervisors may designate other places (e.g. fire, police or sheriff stations) to receive babies being abandoned, to date such places have not yet been so designated.

OBJECTIVE

The Health and Human Services Committee's objective was to decrease the loss of life of abandoned newborn

METHODOLOGY

A number of hospitals were queried by mail or by telephone regarding their knowledge and policy about this new legislation. (California Penal Code 271.5)

FINDINGS

Recently it was reported that the police were looking for the individual who had abandoned a baby in a hospital. On the surface, it appeared that this problem was in contradiction to the stated purpose of the law. Further investigation revealed that there was a complication and that the spirit as well as the letter of the law was being followed.

The Committee was encouraged that every hospital contacted had knowledge of the law and had a protocol in place to deal with abandoned babies. However, none of the institutions had had any practical experience with abandoned babies.

None of the Health and Human Services Committee members of the Los Angeles County Civil Grand Jury 2001-2002 had first hand knowledge of this law. It was discovered that the allocated funds for publicizing this law had not been released.

Health & Human Services Committee

ABANDONMENT OF NEWBORNS

RECOMMENDATIONS

22. The Health & Human Services Committee recommends that the Board of Supervisors should encourage the passage of the enabling legislation to release the allocated funds to publicize the provisions of SB 1368 (California Penal Code 271.5).

23. The Health & Human Services Committee recommends that the Board of Supervisors should solicit as many public service announcements as possible from the local media, especially those venues that cater to younger people, to inform the public of this new law.

24. The Health & Human Services Committee recommends that the Board of Supervisors should encourage hospitals, libraries, police and fire stations and sheriff facilities to display signs explaining the law.

25. The Health & Human Services Committee recommends that the Board of Supervisors should encourage the boards of education in Los Angeles County to include information about the basics of SB 1368 in health curricula.

26. The Health & Human Services Committee recommends that the Board of Supervisors should designate a specific day or week to publicize the abandoned baby problem.

27. The Health & Human Services Committee recommends that the Board of Supervisors should designate other appropriate facilities to accept unwanted newborn.

HEALTH & HUMAN SERVICES COMMITTEE

Patient Advocates

BACKGROUND

Due to the stress of illness, many communications between doctor and patient and hospital staff and patient are lost or misinterpreted. Family members also may have difficulty understanding or interpreting what is said or written due to the stress of illness of a loved one.

Helping patients who alone may be incapable of making decisions, helping families decide on courses of action, discussing and interpreting forms and insurance mandates, and generally making the hospital stay more comfortable are some of the benefits of patient advocate and ombudsman programs.

The use of patient advocates or ombudsman programs in hospitals would be helpful in giving their patient population a chance to resolve any conflicts that may arise secondary to a hospital stay.

A conflict of interest could occur if the advocate were an employee of the hospital. If patient advocates were all volunteers, the economics of the situation might change to the point that smaller hospitals would be more likely to start a program in their institutions.

OBJECTIVE

The Health and Human Services Committee investigated to what extent hospitals embraced the concept of ombudsman services or patient advocacy.

METHODOLOGY

Hospitals were randomly selected and were contacted by letter or telephone. Usually the respondent was someone in hospital administration or nursing administration. Some were reluctant to discuss any hospital policy over the telephone, while others were immediately forthcoming with information and details.

FINDINGS

Only 25% of the hospitals questioned had programs for patient advocacy. Some were considered patient advocates, some were called ombudsman, and some were under the umbrella title "member services."

In general, the larger hospitals had these programs and the smaller facilities did not. Some patient advocates were employed by the hospitals in the administrative office or by nursing administration. Volunteers staffed other patient advocate positions. There seemed to be no set pattern in this area of health care.

In the reality of today's hospital economics, some institutions feel that the cost is justified by the increased goodwill and conflict resolution potential that these programs offer. The remainder cannot justify the costs by the benefits received.

Health & Human Services Committee

PATIENT ADVOCATES

RECOMMENDATIONS

28. Health & Human Services Committee recommends that the Board of Supervisors should initiate a study of hospitals with a county contract that have advocacy programs and those that do not. They should compare patient and financial outcomes to determine the value of an advocacy program to the patient and to the hospital.

29. The Health & Human Services Committee recommends that the Department of Health Services should direct their hospitals to start a program of patient advocacy training for volunteers. Conflicts of interest with the hospital would be less likely to arise than if a patient advocate were an employee of the hospital.

30. The Health & Human Services Committee recommends that the Department of Health Services should direct their hospitals to disseminate information on the patient advocacy programs in their hospitals upon patient admission, with emphasis on just what services are available to patients and their families. This information should stress the independent nature of the program as a means of good public and patient relations.

HEALTH & HUMAN SERVICES COMMITTEE

Retail Food Inspection

BACKGROUND

It is estimated that 9,000 Americans die each year from food related illness. Millions more become ill from contaminated or improperly handled food. Los Angeles County administers a retail food inspection program under the Environmental Health Division of the Department of Health Services. The goal of this program is to lessen or eliminate such occurrences here.

In the last few years, many restaurants in Los Angeles County have been issued plaques bearing a rating symbol based on the results of an inspection of their premises. This plaque must be posted in an area that is clearly visible to patrons and the public. This posting was based on an ordinance (#97-0071) adopted by the Los Angeles County Board of Supervisors on January 16, 1998.

Some cities in the county do not require posting of grades, although the restaurants in these cities are inspected with the same regularity as those in the conforming cities. (Not all city councils have adopted the County Ordinance.) The usual frequency of inspection is three times yearly.

Additionally, public notification signs must be clearly posted. These signs state: "All public health questions/concerns regarding this food establishment should be directed to the local Environmental Health Office." The address and phone number is provided.

Each establishment must have a trained Certified Food Handler whose job is to maintain the standards and practices outlined by the Environmental Health Division of the Department of Health Services, and to teach the other employees about these standards and practices and how to conform to them.

Continuing education for food handlers is offered in many languages for ongoing educational support.

The rating system grades (A, B, C, or a numerical score if it is below 70, the low point for a C) are based on an extensive and thorough inspection of the facility. Deductions from 100 are based on the findings, with specific deductions for specific infractions. Some infractions are considered so dangerous that businesses with those infractions are closed immediately and remain closed until the dangerous infraction is remedied and the premises reinspected.

An inspection may be repeated at the owner's request and expense sooner than the next scheduled inspection (for example, if a grade has been lowered and the owner wants to show the defect has been corrected).

When an inspection has been completed, the inspector goes over the comprehensive form with the responsible party. The inspection form used is specific and detailed. Each violation has a prescribed point deduction and each deduction is fully explained. The problem is also explained.

OBJECTIVE

The objective of the Health and Human Services Committee was to evaluate the food inspection system for restaurants.

METHODOLOGY

The Environmental Health Division of the Department of Health Services presented a retail food service inspection orientation to the Health and Human Services Committee. On subsequent days, members of the committee accompanied inspectors on their inspections. The inspections were unannounced, the only exception being a reinspection at the request of an owner. As observers, the committee members were in the kitchens and storerooms and freezers and refrigerators right along with the inspectors. These inspections were conducted during normal business hours.

FINDINGS

The inspectors that were observed were dedicated and hard working. The inspection of restaurants was a much more physically demanding job than anticipated by the observers. Looking underneath and behind cabinets, refrigerators, ice dispensers, soda dispensers and any other structure found in a restaurant was not an easy job. Looking at the inside of the front face of an ice dispenser required a back-twisting, neck-twisting move. These acrobatic moves and awkward positions assumed in the course of an inspection must take a toll on the examiners. Much information was gleaned from these maneuvers—that is, how would one ever know that mold was growing inside the front face of the ice dispenser if one didn't look?

The inspectors wanted to see conditions before anyone had any inkling that they were going to be inspected. In some inspections, the inspector and observers hurried through the parking lot going directly into the restaurant and immediately into the kitchen. Some owners or operators might recognize the inspectors and try to modify or hide some unacceptable practices if alerted to the impending inspection.

The inspections were purposefully geared to be non-confrontational. The gentle, but firm demeanor of the inspectors took just the right tone so that the experience for the operator was an educational one rather than a punitive one - even though the restaurant may have gone down in rating. This aspect of the inspection was particularly impressive to the observers.

There was a skillfully detailed form that the inspector filled out during and immediately following the inspection. It specified what regulations or rules were broken, the deductions for each of the infractions, and the method and means to fix the problem. Completing the form took quite some time, sometimes as long as the inspection when there were many violations. Then the inspector went over the form in detail with the responsible party to point out, discuss, and suggest modification for each problem. This also was very time consuming, but very educational for the responsible party - as it was for the observers.

One of the reference manuals used is the "Retail Food Inspection Guide" published by the County of Los Angeles Department of Health Services. This manual [H-3046 (5/00)] contains a copy of the Food Inspection Report. Each part of the inspection has a number that is keyed to an explanation in the latter half of the manual. It also has a summary of the laws and regulations for the violations listed in the inspector's report. (See attached Food Inspection Report Form.)

Another manual published by the County Department of Health Services is titled "Food Handler's Guide For Retail Food Establishments." It is meant to be instructional for food handlers and has a great deal of information regarding the maintenance of good practices in the retail food industry. It is written in very simple language with many illustrations.

The basic tools of an inspector are an instant read food thermometer, a flashlight, and a metal case that holds forms and is used as a writing surface during an inspection. These tools are sometimes awkward to manipulate in the close quarters of a kitchen. Inspections would be easier and faster if the access to this equipment were simple and efficient.

Getting "down and dirty" appeared to be a regular routine for the inspectors. It was not unusual for them to get down on their knees to look under anything they had to inspect that was close to the floor. Additionally, because many of the kitchens were small, it was not uncommon for the inspectors to stain their clothes from work surfaces. The inspectors were professionally dressed. Their cleaning bills must have been excessive if the inspectors that were observed were the norm.

In general, large national restaurant chains have stringent guidelines they expect their franchisees to uphold. Therefore, franchisees have serious problems with their parent company if they get less than an "A" rating.

In the polyglot area that is Los Angeles, many languages are spoken and many ideas regarding food preparation are brought to this county from other countries. The proprietors and workers in ethnic restaurants may have traditions and practices that do not necessarily follow the guidelines that are required for safe food handling. In Los Angeles County, sometimes the difference in proper versus improper food handling techniques is very subtle. Explaining the changes required to conform may be difficult if one does not have the nuances of other cultures and languages.

A copy of the prior inspection report must be kept at each establishment. It must conform to the posted grade or scorecard. This report must be available to the public if requested.

Health & Human Services Committee

RETAIL FOOD INSPECTION

RECOMMENDATIONS

31. Health & Human Services Committee recommends that the Instructors in the Environmental Health Division of the Department of Health Services should include inspector training regarding body mechanics to prevent their having back and joint problems.

32. The Health & Human Services Committee recommends that the Environmental Health Division of the Department of Health Services should design and provide a tool belt to hold the equipment that all inspectors must carry.

33. The Health & Human Services Committee recommends that the Environmental Health Division of the Department of Health Services should consider a professional work garment that would preserve the inspectors' clothes and that could either be used in conjunction with a tool belt or have pockets and loops that would obviate the need for a tool belt. The negative impact of this recommendation is that if the garment were distinctive enough, the restaurant personnel would recognize the inspector and that would give them some warning if surprise were to be a factor.

34. The Health & Human Services Committee recommends that if the personnel in the restaurant are not fluent in English, or if language subtleties could present problems, the Department of Health Services should try to match the inspectors who could speak the language with the language spoken at the restaurant.

JAILS COMMITTEE

Detention Facilities

BACKGROUND

The Los Angeles County jail system is the largest in the United States. The daily inmate population in the County exceeds 23,000 men and women. In addition, over 4,000 juveniles are detained daily in camps, juvenile halls and youth detention facilities. By contract with the Immigration and Naturalization Service (INS), the Sheriff also houses in excess of 800 INS prisoners awaiting disposition of their cases. These facilities could potentially hold over 1100 detainees and authorities have indicated possible expansion in the near future.

The Los Angeles County Civil Grand Jury Jails Committee 2001-2002, is mandated by the California Penal Code §919(a) and (b) to inspect county and municipal police department jails and lockups, court holding cells, juvenile camps, juvenile detention centers, and other penal institutions. These inspections include, but are not limited to, housing conditions, availability of telephones, medical needs, food service with dietary considerations, number of staff and their training background, policy and procedures manuals, local fire inspection reports, use of safety – sobering – and detoxification cells, availability of rules and disciplinary penalty manuals, availability of personal care items, and conditions of the restrooms and showers.

The grand jury may inquire into the case of any person imprisoned in the jails of the county on a criminal charge but not yet indicted. The grand jury shall inquire into the condition and management of the public prisons within the County.

Other agencies conduct in-depth inspections of these facilities on an annual or semi-annual basis. Those agencies include, local and state health departments, local fire departments, the Board of Corrections, and the Department of Justice. The agencies report their findings directly to the authorities in charge of said facility, while the Civil Grand Jury conducts "snapshot" inspections for reporting directly to the Los Angeles County Board of Supervisors.

Many of the categories listed above have minimum standards. The standards are interpreted by the California Board of Corrections and are applied to adult and juvenile detention facilities as set forth in Titles 15 and 24 of the California Penal Code.

OBJECTIVES

The objective of the Civil Grand Jury 2001-2002 was to carry out the mandate as set forth in the California Penal Code Titles 15 and 24. The committee's goal was to inspect each adult and juvenile detention facility operated in Los Angeles County by local agencies, make recommendations for improvement, and recognize excellence.

METHODOLOGY

A list of detention facilities was obtained from previous grand jury reports. The Jails Committee revised and updated the list and inspection areas were assigned. The county was divided into four districts. Each district was assigned one team of two committee members each. A fifth team performed selected inspections drawn from all districts.

The detention facilities inspection process for the Civil Grand Jury 2001-2002 Jails Committee was discussed at committee meetings and implemented after a consensus was obtained.

A field inspection form (see Attachment A) was devised to collect common data from each of the facilities. The data fields found on the inspection form were derived from the minimum standards enumerated in Titles 15 and 24. The data were then compiled in spreadsheet format for quick reference.

The final report includes spreadsheets with detailed information regarding data gathered during inspections. Each facility was then rated on the data gathered, anecdotal information, and personal observations. A scale ranging from excellent, above average, average, to substandard was used. In some cases, when a facility was assessed to be substandard, a second team conducted follow-up inspections. Suggestions and recommendations were made to the facility managers and where a problem was pervasive, the responsible department head was contacted and exit interviews conducted.

An overall view, in narrative form of excellent and problematic facilities would be noted in the final report. The Jails Committee felt using this comparative procedure would best raise the attention level of all concerned, including the 2002–2003 Civil Grand Jury. Past grand juries' final reports were compared with current observations, to determine progress made toward long-term corrective goals.

This section of the report includes information about juvenile camps, juvenile halls, juvenile facilities for the mentally challenged, probation areas for youth recovery upon release, Immigration and Naturalization Service facilities, adult detention facilities including both holding cells and jails, and adult specialty facilities.

FINDINGS

JUVINILE DETENTION FACILITIES
Probation Department

The Los Angeles County Juvenile Probation Department exists for the purpose of assisting the youth in the at risk population. Programs are offered to aid young people before and after they become involved in the justice system.

Many dedicated Probation Department employees were found willing and able to assist juveniles with a myriad of justice system related problems. They were found in the schools, camps, and other detention facilities.

Early intervention and prevention are preferable over detention and are the keystones to the Probation Department's mandate. They are intended to avert chronic delinquency, substance abuse and gang violence.

A small sampling of pre-detention programs are as follows:

Supervision – Probation Department supervisors are assigned to identify potential or real justice system offenders and to assist in keeping the individuals on a lawful path.

School Based Supervision – Selected middle and senior high schools have probation officers stationed on campus.

School Based Deputies – Deputies are assigned to campuses where there is a high concentration of gang activities. These deputies are meant to produce a high profile law enforcement presence as a deterrent to anti-social behavior.

Gang Units – Deputies work with youth involved in gang activities.

Youth Placement – For various reasons, a child may not be able to live at home. The probation officers involved in this program will seek placement for juveniles outside of the home. In some instance they may recommend placement in juvenile camps or residential care facilities.

Probation Department satellite offices - There are 15 offices scattered throughout the county dedicated to assisting potential juvenile offenders. The deputies assigned to these offices work with community based organizations to provide services for at risk youth.

The Probation Department serves not only those in trouble but also those who are at risk. During the Committee's visits to many diverse facilities under the Probation Department's control, the committee noted that a great number of programs have been implemented with the intention of keeping at risk juveniles on the path to becoming good citizens. It was surprising how little public awareness was paid to those programs considering their positive results.

The following are examples of those programs:

The Los Angeles Theatre Works Arts and Children Project – Since 1984, this program has been providing theatre experience to young people who are receiving their education as wards of the courts and to the youth at risk in their own communities. The organization currently serves 2,000 youngsters annually and has served 50,000 since the inception of the project.

The Honors Drama Ensemble brings positive role models and messages to the young and impressionable.

The Juvenile Alternative Work Service (JAWS) provides 13 to 18 year olds an innovative alternative to detention, allowing probationers to remain in their communities with sanctions instead of custody.

The JAWS program provides probation supervised weekend and holiday labor crews employed on a variety of projects. Some of the work projects include graffiti removal, clearing brush and debris from flood control basins, and litter removal from the roadside.

The Camp Community Transition Program (CCTP) provides aftercare services upon the minor's release back into the community. This furlough program is intensively supervised to insure school enrollment, community service, and participation in selected community based organization programs.

Teen Court offers an alternative sanction in the form of a diversion program for first time juvenile offenders instead of formal delinquency proceedings. The Court consists of a volunteer bench officer, a court coordinator either a Deputy Probation Officer (DPO) or a reserve DPO and six peers. The Teen Court is a cooperative effort between students, parents, juvenile offenders, schools, the courts, the Probation Department, and the community.

Selected juveniles volunteer to participate in the proceedings and the penalties accessed by the Court. Teen Court offers juveniles the opportunity to improve their behavior within six months, thereby allowing the youth to avoid the formal justice system.

Youth Camps

All juvenile camps were inspected using a modified adult field reporting form (see Attachment B) as a basis to gather information and make comparisons. The following are brief examples of the information gathered during inspections of juvenile camps in the county.

Challenger Memorial Youth Center - camp is comprised of six individual camps
Camp Challenger - facility in general

The Jails Committee was informed of a proposal to install an electronic monitoring station in the lobby of Camp Challenger. The monitoring station would be used by adult probationers to "check in" with the Probation Department. The same lobby area was used by juvenile detainees to greet visitors. Adult probationers should not be allowed to mix with youthful offenders who may be vulnerable to negative adult influences. The mix of adults and juveniles under

these circumstances was not appropriate. This proposal should not be implemented for any reason.

The grounds were above average with a working productive garden. Additional gardens and a greenhouse will be built in the summer of 2002. Special Housing Unit School and facilities were above average with only minor maintenance needs.

The schools were all physically above average with good educational programs, computer labs, and knowledgeable instructors.

The kitchen was in excellent working order with only minor repair work needed.

Both gymnasiums were in good condition. However, because of a lack of living space for the staff, one gymnasium was being used to house staff. This need superceded the use of the gymnasium by the juveniles.

The two laundries were functional, however, there were major problems with the industrial washers and dryers. They were over fourteen years old and constantly in need of repair. Until Ancillary Support Services fills its vacant items (employee vacancies), the camps have to use detainees to work in the laundry. Individuals on assistance or performing community service have performed this work in the past, but this is no longer the case.

The Center's swimming pool was unusable because the money allocated was not spent to resurface the decking.

Over 700 detainees have been denied the use of the pool in an extremely hot environment for over two years. This repair work should be performed immediately. Repair work cost was estimated to be $15,000.

Lacking parity with other camps, the Center was seriously understaffed, with a 1 to 15 staff to detainee ratio. Safety, for both the juvenile population and the resident staff is highly suspect given this ratio.

The security television monitoring system was 13 years old. An upgraded system would assist the staff with monitoring activities especially considering the low staffing ratio.

Grants and donations provided for special programs should be modeled at other camps in the juvenile system.

The following is a sample of those programs:

Street Smart – This program offers anger management courses for violent offenders. The program begins in the camp and continues upon release of the offender with a community-based program.

Bytes and Chips – The Bytes and Chips computer lab prints a newspaper every 40 days. The lab class teaches computer technology to the juveniles. This program merits a corporate sponsorship.

Challenger Memorial Youth Center (comprised of six individual camps)

Camp Jarvis (above average) The skylights were dirty. There were no detainee grievance forms on file.

Camp McNair (above average) The bathrooms were in need of minor repair work. The skylights were dirty.

Camp Orizuka (female residence) (above average) The bathroom was in need of minor maintenance and repair. The skylights were dirty.

Camp Resnick (average) The skylights were dirty. Tiles in the bathroom were broken. Privacy dividers in the bathroom were in need of repair. The metal welds on bathroom windows were sharp, presenting a safety issue.

Camp Scobee (average) The air conditioning ducts needed cleaning. The skylights were dirty. There were only a few books and other reading materials available to the detainees. A new countertop was needed in the supervisors' work area.
There were many chipped and broken tiles in the bathrooms that needed to be replaced. The painted surfaces needed cleaning or touchup work in many areas throughout the camp.

Camp Smith (average) The Violent Alternatives Program for gang members has been established at this camp as a pilot program. Some urinals were not working. There were chipped tiles in the bathroom. The painted surfaces needed cleaning or touchup work. The water basins were leaking.

Other Juvenile Camps

Camp Gonzales (above average) The new camp director has improved the overall condition of the camp since taking this assignment. However, there was a critical shortage of books and shelving at this facility. This facility needed an emergency generator.

The commercial washing machine was not working. Since this camp provides laundry services to other camps, a backup system of multiple washers and dryers should be installed.

Camp Holton (substandard) Many of the problems noted in previous Grand Jury reports were still present. For example, the Special Housing Unit ceiling tiles still needed to be replaced, the dining area floor was not repaired, and new tables and chairs were still needed. Past final reports recommended bathroom vent fans, which have never been installed. In addition, the air conditioning was not sufficient. The dorm floors needed maintenance and repair. The main gates were not operable. The security lighting illuminating the campgrounds was insufficient to provide a margin of safety. The camp was in need of a stand-alone generator. The grounds of this facility were in dire need of irrigation.

Camp Munz (substandard) Many things needed repair at this camp. Foremost was the main sewer; it was in disrepair and desperately needed attention.
There were many areas throughout the camp that were substandard such as the restrooms, the paint, and the electrical system. Vocational training programs were lacking. The kitchen needed a tilt grill and potato chopper, all considered minor when compared to the sewer problem.

Camp Mendenhall (average) The aging of this facility was beginning to show in its need for minor repairs. The major problem at this camp was the gymnasium's use as a classroom because of a lack of adequate classroom space. The camp was scheduled to have a double modular classroom built in 1999. Monies were appropriated (November 28, 1999) on the recommendation of the Board of Supervisors and construction begun. Due to a lack of coordination and communications, only a single classroom was built and it was still not ready for use.

An in-house audit found that in 1998-1999 the Average Daily Attendance (ADA) at this camp was 110 students, equating to the need for 6.5 classrooms. In 1999-2000, the ADA dropped to 100, lowering the need for classrooms to 6. In 2000-2001 the ADA rose to 110, again equating to the need for 6.5 classrooms. Camp Mendenhall has five classrooms.

Camp Routh (fire crew camp) (excellent) This was a good example of what can be accomplished with hard work and dedication by the directors and staff.
Many excellent programs were available to the youth in addition to the required schooling. The camp needed a complete new restroom facility and a commercial washer to clean the heavy fire fighting clothing.

Camp Scott (female juvenile) (substandard) The dilapidated dorms were in the process of being replaced. Some problems visible in 1999-2000 still existed such as broken or missing ceiling tiles and moldy carpeting in classrooms from a leaking roof. The roof had been replaced. The gym was in need of maintenance and repair.

There were inadequate numbers of books and games. The electrical system needed immediate attention. Internal Services Division estimated minimum allocation of $20,000 is needed to remedy electrical cable problems that cause phone line problems and electrical outages at both camps Scott and neighboring Camp Scudder.

The Civil Grand Jury performed an independent audit of the Average Daily Attendance (ADA). In 1999-2000, the ADA was 93, equating to the need for slightly less then five and half classrooms. The 2000-2001 ADA rose to 101 or a need for slightly less then six classrooms. This camp has only five.

Camp Scudder (substandard) Problems that existed two years ago were still apparent and new problems were discovered during this inspection. For example, the freezer latches all needed to be replaced, the commercial clothes dryer had not operated for months. More footwear for the detainees was needed than what was being supplied. The gymnasium floor needed maintenance. The irrigation system was inadequate. The grounds were obviously under watered and dry. Electrical outages were common and appeared to be related to a cable shared by the two camps. The electrical system needed immediate attention. A minimum allocation of $20,000, as estimated by Internal Services Division, was needed to remedy electrical cable problems that caused phone line disruption and electrical outages at both camps Scudder and neighboring Camp Scott.

Similar to Camp Mendenhall, Camp Scudder also was promised two new classrooms. The funds were appropriated, but due to a lack of coordination and communications only one was completed. It had building code violations and security problems and was still not in use.

The Civil Grand Jury performed an independent audit of the Average Daily Attendance (ADA). In 1999-2000, the ADA was 102, equating to the need for slightly less then six classrooms. The 2000-2001 ADA rose to 103 or a need for slightly over six classrooms. This camp has only five. Inappropriately, the gymnasium, lunchroom, barrack's dayroom and the grounds were used to make up the classroom shortfall.

Camp Kilpatrick (sports camp) (average) There were other good youth oriented programs available beyond the sports program at this camp. The computer lab is the best in the camp system thanks to the instructors for researching and obtaining grant monies. The grounds, however, needed improved maintenance. Graffiti was visible throughout the camp. Poor housekeeping habits on the part of the juveniles were observed in the dorm. The gymnasium has been red tagged since the 1994 Northridge earthquake. This camp too is in need of a commercial clothes dryer.

Gopher holes were seen over the area of the sports fields. The fields were uneven and generally in poor shape. These conditions were a safety hazard to anyone participating in sporting activities.

Camp Miller (above average, first team inspection) The staff was found to be concerned and involved with the juvenile population. The kitchen was in good working order. The

gymnasium was still red tagged from the 1994 Northridge earthquake. Members of the staff were discouraged and did not believe repairs were forthcoming. The grounds were in excellent condition and supported a working garden. The dorm was clean and orderly. The library was extensive and orderly. The classrooms were impressive and demonstrated a caring environment. The vending machines were inside the camp but off limits to the juveniles creating an unreasonable temptation. Gardening, landscaping, culinary arts and construction work were emphasized. There was a Reserve Officer Training Corps. program available.

Camp Miller (average, second team inspection) The camp grounds were in disarray; broken cement sidewalks presented safety hazards due to ongoing construction. Long-term sewer problems existed in the kitchen. The gymnasium was still red tagged because of damage from the 1994 Northridge earthquake.

Camp Afflebaugh (substandard) This camp had many problems some of which have been carried over from two years ago. There was a need for additional reading material and clothing. The camp had open sewer drains and overall maintenance of plumbing and sewer system was needed. The hot water tank and plumbing repairs promised in 1999 were still not completed. The freezer doors in the kitchen needed seal replacement. There was no sporting equipment available. The day of the inspection a large number of the youth were performing maintenance tasks in preparation for a Board of Corrections inspection later that week.

Juveniles participating in work-release programs may be assigned away from school. Several sources indicated that these juveniles were being pulled from school to perform maintenance functions for periods up to six hours. This activity was in violation of agreements with the Board of Supervisors, the Probation Commission, and the California Education Code mandate to provide 240 minutes of education per day.

Camp Paige - Fire Camp (substandard) The newly installed air conditioning was marginally effective. All the handheld radios used by staff were outdated and rarely worked. There were inadequate quantities of bedding, clothing, fire boots, and sports equipment. The staff's computers were inadequate.

The school's computer lab has a need for 10 PCs, new disc drives, airport cards, and a master computer at the teachers desk to monitor student activity. Staff morale was low and there was a high employee turnover rate. There was a need for a refresher course on the State Correctional Office's 80-hour educational program. Many juveniles were outside performing maintenance duty in preparation for a Board of Corrections inspection.

Juveniles participating in work-release programs may be assigned away from school. Several sources indicated that these juveniles were pulled from school to perform maintenance functions for periods up to six hours. This activity was in violation of agreements between the Board of Supervisors and the Probation Commission, and the

provisions of the California Education Code's mandate to provide 240 minutes of education per day.

Camp Glen Rockey (substandard) There was a need for a considerable amount of maintenance and repair throughout this camp. For example, ceiling tiles in Special Housing Unit needed replacement. The plumbing in the shower was in need of repair or replacement. The gymnasium needed to be replaced. It was still red tagged from 1994 Northridge earthquake. Barrack's bathroom ceiling tiles needed to be replaced. The bathroom exhaust fan installation requested in 1999-2000 was never considered or installed. A hole in a wall noted in a 1999-2000 inspection was still evident.

The camp school needed two additional classrooms and textbooks. The existing computers needed repair and additional computers were needed in the school. The school was in the process of starting English language classes and needed teaching aids. Many juveniles were seen cleaning and painting for a Board of Corrections inspection.

Juveniles participating in work-release programs may be assigned away from school. Several sources indicated that these juveniles were pulled from school to perform maintenance functions for periods up to six hours.

This activity was in violation of agreements between the Board of Supervisors and the Probation Commission and the California Education Code's mandate to provide 240 minutes of education per day.

Juvenile Facility For The Mentally Challenged

Camp Dorothy Kirby (average, first team inspection) The rating was downgraded from that of two years ago. The camp was beginning to show signs of excessive wear on the buildings, the furniture, and the general overall condition of the camp. The nurse's station needed a fax machine and copier. Several of the cottages were in excellent shape; others needed maintenance and repair.

The inspectors noted that this camp, as opposed to all others that were visited, had a much different grievance system for the detainees. Complaints filed by the juveniles go directly to the dorm supervisor rather than to the camp director. All other camps have a locked box opened only by the camp director.

A number of juvenile females were asked about problems they encountered. Several individuals spoke of serious problems with several teachers and a lack of response to their grievances.

Camp Dorothy Kirby (average, second team inspection) A follow-up inspection was completed a month later and the same conditions existed. The Probation Department should take a serious look at this facility.

MacLaren Children's Emergency Shelter (not rated) The Civil Grand Jury decided that this facility required an in-depth audit and was so assigned to the Social Services Committee. See Social Services section of this final report.

Juvenile Halls

Eastlake Central Juvenile Hall & Court Holding Area (substandard) The court holding area for juveniles was controlled by the Probation Department. There was adequate space for separation.

The juvenile area was undergoing a complete remodel begun in September of 2001. The capacity was rated at 438 by the Board of Corrections, yet the average daily population was well over 500, and was 600 the day of the inspection. Taking into consideration the ongoing construction, the inspectors noted that many standard safety precautions were not in force. The security lighting was inadequate. The electrical and water systems functioned poorly. The facility had been without electricity since 8:30 pm the previous day. Security cameras would be of great assistance in controlling the large daily population.

There were few positive observations that could be noted about the facility other than the director and staff all seemed genuinely interested in doing anything they could for the youth. This facility, with aid from the State Grant Funding for Juvenile Halls, will be building a new 240-bed unit at the cost of $33,503,454.

Los Padrinos Juvenile Hall (above average) There were new buildings under construction with plans for additional work. This will be an excellent facility in the future, with an excellent computer lab. The staff and teachers appeared to be genuinely concerned for the youth.

In general, the facility was in good working order and had a good appearance. The only major problem encountered was a frequent drain line stoppage in the kitchen, which could become a health issue. Probation Department's staff has a high turnover rate. An additional 240-bed unit was under construction with the aid of $37,067,000 from the State Grant Funding for Juvenile Halls.

Barry Nidorf Juvenile Hall and Courts Holding Area (above average) The juvenile court holding facilities were adequate for the number of juveniles they received. Like all the juvenile halls, overcrowding was common. The boy's gym is being rebuilt. A new hot water system was installed. Internal Services Division was slow to respond to maintenance problems at this facility as at all other facilities. Not enough emphasis was placed on vocational training at this and all detention facilities.

Jails Committee

JUVENILE DETENTION FACILITIES

RECOMMENDATIONS

35. The Jails Committee recommends that the Probation Department should hire an adequate number of personnel to provide for the safety of the staff and detainees at all camps. If the Probation Department cannot fund staff needs, the Board of Supervisors should address funding shortfalls.

36. Jails Committee recommends that the Probation Department should require new staff to spend a minimum of two years at the same training facility before rotation to a new facility.

37. The Jails Committee recommends that the Probation Department should arrange for the immediate repair of all gymnasiums and swimming pools in the camp system.

38. The Jails Committee recommends that the Probation Department should implement additional and more varied occupational training programs for juvenile detainees.

39. The Jails Committee recommends that the Probation Department should allow camp directors more discretion to contract with outside vendors for emergency maintenance problems and in some cases, regular maintenance.

40. The Jails Committee recommends that the Probation Department directors and Los Angeles County Office of Education principals at each facility should be required to submit priority maintenance lists monthly to Internal Services Division.

41. The Jails Committee recommends that the Board of Supervisors should require the Internal Services Division to reprioritize maintenance schedules and place more emphasis on the camp's needs.

42. The Jails Committee recommends that the Probation Department should expand it's effort to seek public grants and private partnerships to fill needs throughout the camp system. Sponsorships and corporate "adoption" programs should be considered.

43. The Jails Committee recommends that the Probation Department should establish a relationship with California National Guard and other military units to procure clothing for the camp detainees.

44. The Jails Committee recommends that the Probation Department should purchase stand-alone generators to provide power during outages for all juvenile facilities.

45. The Jails Committee recommends that the Probation Department should replace outdated hand-held radios and ensure there are sufficient quantities to provide for the safety of staff and detainees. The Probation Department should make inquiries to other County departments that may be replacing aging but workable hand-held radios.

46. The Jails Committee recommends that the Probation Department should never allow the installation of adult probation electronic monitoring equipment at any juvenile facility.

47. The Jails Committee recommends that the Probation Department should move candy and soft drink vending machines visible on the camp grounds out of the view of the detainees.

ADULT DETENTION FACILITIES

Immigration and Naturalization Service

Mira Loma Detention Facility (excellent) The Sheriff's Department operates Mira Loma Detention Facility in Lancaster under contract with the Immigration and Naturalization Service. All Immigration and Naturalization Service standards apply with regard to staffing, health care, etc. in conjunction with California Title 15. At present this facility has over 800 inmates with a rated capacity of 1100 should it ever be needed. There are three federal courts on the grounds. There were few problems with detainees when compared to other inmate populations. The facility was in excellent condition, the grounds were well maintained, the staff morale was high and little could be found to fault.

Adult Detention Facilities

The same methodology for inspecting juvenile facilities was applied to adult jails and court holding areas. Most of the Superior Court buildings, Los Angeles Police Stations and Sheriff Stations are in excess of 30 years old and are in need of major repairs or replacement. However, rather than concluding that all buildings should simply be replaced, the Committee made an effort to rate the facilities from excellent to substandard. While more assessment would be needed to establish a prioritized replacement list, this simple rating system could be used as a beginning point. Only examples of excellent and substandard rated facilities have short narrative statements following the facility rating. Facilities with other ratings are simply listed.

Excellent Facilities

La Crescenta Sheriff Station (excellent) The station deputies have established an excellent rapport with the community by hosting such events as a "Haunted Jail" open house. This was an exceptionally well-maintained facility. It had superior quality fire air packs and fire fighting turnout gear. Notched keys match notched door handles in case sightless entry was needed in an emergency. Innovative video booth visitations were used. Juvenile detainees were treated to snacks provided by the deputies before processing.

Alhambra Police Department (excellent) The facility was operated by civilian jailers employed by CSI Corporation (private contractor). This facility was one of the best maintained in the county. There was no lack of equipment.

Lancaster Sheriff Station (excellent) This facility was another example of a well run and maintained station. There was a lack of some equipment. There was high morale amongst the staff; quite an accomplishment given the 1200 prisoners processed each month. The staff should be commended for the excellent job they perform.

Whittier Police Department (excellent) This was another facility run by civilian jailers from CSI. Whittier Police Department employed, from their own budget, two Los Angeles County Probation Department officers and one assistant district attorney full

time to provide comprehensive services to juveniles. This facility might normally have been rated average, however, because of this proactive approach to assisting the youth in the community, it was rated as excellent.

Carson Sheriff Station (excellent) This was another example of a well maintained efficiently operated station. All the appropriate manuals were up to date. The facility was in superb condition. All personnel were very knowledgeable in every aspect of their profession.

Glendora Police Station (excellent) This was a very clean facility. Each squad car carried a defibrillator.

Century Regional Detention Facility (excellent) This was an excellent facility with a capacity of 1800 prisoners. Minimal staffing was required due to the central viewing pods much like Twin Towers. All inmates were given complete medical exams. Several large clean kitchens provided food services and there were four arraignment courts. It had the latest in all necessary equipment and did an excellent job with a small staff.

LAX Airport Courts (excellent) This facility was two years old and enjoyed all the latest in equipment. It was a very clean and bright facility. This was a well-run facility with excellent supervisory practices in place. The officers were motivated and enjoyed their work and working conditions.

Palos Verdes Estates Police Department (excellent) This facility was extremely well organized and clean. The personnel were well informed. Fire and medical personnel were available at the fire station next door.

Manhattan Beach Police Department (excellent) A very well organized facility. Personnel were proud of and dedicated to their facility. The jailers were especially proud of innovate ideas they had put into action such as painting game boards on mess tables.

Beverly Hills Police Department (excellent) The jail facility was extremely clean and well organized. Personal care amenities such as a change of clothes were available. Water valves were placed outside the cells to curb water damage to the facility if detainees misused sinks or showers.

Culver City Police Department (excellent) Despite being an older facility, it was extremely clean and well organized. This facility was painted with anti-graffiti paint. Exceptional separation accommodations were noted.

San Fernando Police Department (excellent) This facility was new, light, clean and exceptionally well maintained. Jail and fire manuals were computerized and regularly updated.

Inglewood Police Department (excellent) This facility was old but clean with an excellent maintenance program. The management was well informed. Food was catered from an outside vendor.

Above Average Facilities

Alhambra Court lockup
Arcadia Police Department Baldwin Park Police Department
Bell Gardens Police Department
Bell Police Department
Beverly Hills Court lockup
Burbank Court lockup
Burbank Police Department Central Court Services lockup
Claremont Police Department
Covina Police Department
Edelman's Children Court
El Monte Police Department,
Foothill Division LAPD
Gardena Police Department
Glendale Court lockup
Glendale Police Department
Hawthorne Police Department Hill Street Courthouse Huntington Park Police Depart
Industry Hills Sheriff Station
Irwindale Police Department
Lakewood Sheriff Station
La Verne Police Department
LAPD Parker Center
Lennox Sheriff Station
Lost Hills Sheriff Station
Marina Del Rey Sheriff Station
Monterey Park Police Depart
Northeast LAPD Holding Area
Malibu Court lockup
Metro Traffic Court lockup
Monrovia-Santa Anita Court
Montebello Police Department
Pasadena Court lockup
Pasadena Police Department Pomona Court lockup
Pomona Police Department
Rio Hondo Court lockup
San Dimas Sheriff Station
San Fernando Court lockup
San Gabriel Police Department San Marino Police Department Santa Monica Police Department South Pasadena Police Dept
Southeast Area LAPD
Southgate Police Department
Temple City Sheriff Station Torrance Police Department Walnut Sheriff Station
West Covina Court lockup
West Covina Police Department,
West Hollywood Sheriff Station
West LAPD
Whittier Court lockup

Average Facilities

77th Street Area LAPD
Altadena Sheriff Station
Antelope Valley Sheriff Station
Azusa Police Department
Barry Nidorf Court lockup
Bellflower Court Lockup
Bellflower Sheriff Station
Catalina Sheriff Station
Central Arraignment Court
Century Sheriff Station
Compton Court Lockup
Compton Juvenile Holding
Compton Sheriff Station
Criminal Courthouse Lockup
Devonshire LAPD
Dodger Stadium Holding
Downey Court Lockup
Downey Police Department
East LA Court Lockup
East LA Sheriff Station
Eastlake Juvenile Court Holding
Eastlake Court lockup
El Segundo Police Department
H. R. Moore Juvenile Facility
Hermosa Beach Police Department
Hollenbeck LAPD
Hollywood Court Lockup
Hollywood LAPD
Hollywood Racetrack Holding
Huntington Park Court Lockup
Inglewood Court Lockup
Inglewood Juvenile Holding
Juvenile Justice Center
Juvenile Justice Court Holding
L. A. Coliseum Holding
L.A.C. Fairgrounds Holding
LAX Airport Holding
LAX LAPD Substation
Lomita Sheriff Station
Long Beach Court Lockup
Long Beach Juvenile Holding
Long Beach Police Department
Los Padrinos Juvenile Holding
Magic Mountain Holding
Maywood Police Department
Men's Central Jail Mental Health
Monrovia Police Department
Newton Area LAPD
North Hollywood Police Department
Norwalk Court Lockup
Norwalk Sheriff
Pasadena Juvenile Holding
Pasadena Rose Bowl Holding
Pico Rivera Sheriff Station
Redondo Beach Police Department
San Pedro Court Lockup
Santa Anita Court (closed)
Santa Anita Racetrack (closed)
Santa Clarita Valley Sheriff
Santa Monica Court Lockup
Sheriff Parks Substation
Sierra Madre Police Department
Signal Hill Police Department
Southgate Court Lockup
Southwest Area LAPD
Staples Center Holding
Twin Towers Men and Women
USC Jail Ward
Valencia Newhall Court Lockup
Valencia Teen Court Holding
Van Nuys Court Lockup
Van Nuys Police Department,
Vernon Police Department
West Valley LAPD
Whittier Juvenile Holding

Substandard Facilities

Central Area LAPD (substandard) This facility was only a temporary holding area for adults and juveniles. The staff was uninformed as to importance of following procedures set down in Titles 15 and 24. The facility was overcrowded and short staffed. This facility lacked computers to process paperwork. As a testament to the lack of staff preparedness, the inspectors found a red arrow on the wall that should have pointed to the location of the fire extinguisher. The arrow actually led to a file cabinet. It took five minutes to locate a fire extinguisher.

Harbor Area LAPD (substandard) The latest update of Titles 15 and 24 was from 1994. The codes are required to be up-dated every two years. The bathroom and facility sanitation conditions were poor at best. The kitchen in general and refrigerator in particular were obviously dirty and would not meet minimum health standards. There is a need to enforce minimum sanitary and health standards.

Pacific Area LAPD (substandard) The station appeared disorganized. The sanitation conditions were only fair. Females, combative detainees, and those with special medical needs, required immediate transportation. This need took officers out of field operations for a minimum of two hours.

Rampart Area LAPD (substandard) This was an old and overcrowded facility. The sanitation conditions were fair. The detectives worked off site due to a remodeling project. Juveniles were kept in chairs near officers' desks allowing them a view of any information left uncovered.

Wilshire Area LAPD (substandard) The security cameras were inoperable. There were numerous safety issues. No remote panic button was available for the jailer to use on inspection walks. The sanitation conditions were fair. This was another station where juveniles were not kept in a separate area but rather in chairs at officers' desks.

Compton Sheriff Station (substandard) This facility was dark, dirty, and dingy. There was a constant anticipation of encountering vermin in this building.

Torrance Court Holding (substandard) The jailer was not well informed; he relied on his staff to answers questions. The jail cells had an excessive amount of graffiti. Deputies felt inmates acting in pro per were responsible because they were allowed writing materials. The facility was to be painted using anti-graffiti paint.

Adult Specialty Facilities

Twin Towers Complex (above average) Twin Towers was a dual-housing facility for male (capacity-2460) and female (capacity-2840) inmates. All female inmates in Los Angeles County were housed at this facility. A respectful attitude between staff and inmates appeared to exist. Medical facilities were accessible 24 hours a day. A choice of religious services were offered. Numerous educational programs and self-help programs were available to the female population. The men held at this facility were mostly mentally ill or drug dependent. The male inmates were held here until they were stabilized. They then were moved to other facilities in the jail system.

Biscailuz Recovery Center (BRC) (Excellent) This facility had the capacity to house and treat 240 inmates. Only one half of the facility was being utilized due to a budget and staffing shortage.

Two programs at the BRC encouraged goal-oriented inmates the opportunity to rehabilitate themselves through the strict regimen offered by the programs. The two programs were The Impact Drug and Alcohol Treatment and the Violence Intervention and Recovery Services. With the tutoring provided by the Hacienda-La Puente School District staff and individuals who had successfully graduated from either program, each inmate at the BRC moves through the programs at a set pace. The inmates recognized why they were selected to participate in the programs at the BRC, what they have done, and expressed very clearly what they intended to do to correct their behavior. There were post-graduation support groups and hot lines for additional help.

This was the only facility in the county where gang members, drug dependant inmates, alternate life style inmates, and general population inmates were housed in the same facility. There appeared to be a high level of respect between the inmates and staff, even more so than the attitudes observed at Twin Towers.

North County Correctional Facility (a.k.a - Wayside Honor Rancho and Peter Pitchess Detention Center) (above average) This facility was situated on 2600 acres and could house 8400 inmates. Prison population on the day of inspection was 6210. Fire Camp 12 operated from this facility. The 42 members of this fire fighting crew were all serving time for misdemeanors.

Programs for the adult detainees ranged from formal education to learning trades. There was a legal library available. The kitchen operated 24 hours a day. Inmates could opt to work in the kitchen and dining rooms.

There were also opportunities to learn cooking and baking skills. There was a working print shop, with outside printing obligations, where inmates could learn the trade.

There seemed to be a great deal of respect between the inmates and jailers. The water system was outdated and needed daily repair. A new security camera system would assistance in managing this large facility and prisoner population. The shower floors

were in poor condition and should be replaced. The law library should be up-dated to include such computer programs as Lexis (computerized law reference library) for those representing themselves. New hot water boilers needed to be installed.

Jails Committee

ADULT DETENTION FACILITIES

RECOMMENDATIONS

48. The Jails Committee recommends that the Sheriff's Department and Los Angeles Police Department should confer and establish a procedure to update all required documents including, Titles 15 and 24, department policy manuals, facility evacuation plans and procedures in their detention facilities. This information should be easily accessible to the jailers.

49. The Jails Committee recommends that the Sheriff's Department should establish a procedure that requires copies of yearly fire inspections to be kept with the jailer.

50. The Jails Committee recommends that the Los Angeles Police Department should establish a procedure that requires copies of yearly fire inspections to be kept with the jailer.

51. The Jails Committee recommends that the Los Angeles Police Department should supply fire fighting turnout gear in any facility that requires fire fighting air packs.

52. The Jails Committee recommends that the Sheriff's Department should supply fire fighting turnout gear in any facility that requires fire fighting air packs.

53. The Jails Committee recommends that the Los Angeles Police Department should provide first aid kits in each detention facility (only 15% of the facilities inspected had any form of first aid kit). They should meet minimum standards set by the American Red Cross.

54. The Jails Committee recommends that the Sheriff's Department should provide first aid kits in each detention facility (only 15% of the facilities inspected had any form of first aid kit). They should meet minimum standards set by the American Red Cross.

55. The Jails Committee recommends that the Los Angeles Police Department should provide automatic defibrillators in all detention facilities. The paramedic response time to most facilities was greater than five minutes, considered to be the upper limit of survival time for cardiac arrest victims.

56. The Jails Committee recommends that the Sheriff's Department should provide automatic defibrillators in all detention facilities. The paramedic response time to most facilities was greater than five minutes, considered to be the upper limit of survival time for cardiac arrest victims.

57. The Jails Committee recommends that the Sheriff's Department should enforce policies regarding sanitary conditions in their facilities as mandated in Title 15, Article 14, §1280.

58. The Jails Committee recommends that the Los Angeles Police Departments should enforce policies regarding sanitary conditions in their facilities as mandated in Title 15, Article 14, §1280.

59. The Jails Committee recommends that the Sheriff's Department should provide fax and copy machines in each facility that relies on prompt communications between the facility and the courts concerning the disposition of detainees.

60. The Jails Committee recommends that the Los Angeles Police Department should provide fax and copy machines in each facility that relies on prompt communications between the facility and the courts concerning the disposition of detainees.

61. The Jails Committee recommends that the Sheriff's Department should maintain an adequate inventory of restraining devices (leg chains) at each facility where transportation of detainees occurs.

62. The Jails Committee recommends that the Board of Supervisors should establish a timeline to replace aging custodial facilities. The Sheriff's Department will have to refurbish or rebuild at least six facilities each year for the next ten years to meet predicted inmate population increases. Consideration should be given to the Inmate Welfare Fund as a funding source.

63. The Jails Committee recommends that the Sheriff's Department, in conjunction with the managers at the North County Correctional Facility, should immediately contract to replace the shower floors, re-pipe the prisoner portion of the facility, and replace the hot water boilers. Using the Inmate Welfare Fund as a funding source should be considered.

64. The Jails Committee recommends that the Sheriff's Department should install a security camera system at the North County Correctional Facility to assist in monitoring the inmate population.

65. The Jails Committee recommends that the Sheriff's Department should install a computerized law library program, such as Lexis Reference Library at the North County Correctional Facility for inmates acting in pro per.

66. The Jails Committee recommends that the Board of Supervisor should initiate an assessment of the practices and effectiveness of rehabilitation programs currently in use in the prison system.

67. The Jails Committee recommends that based on the outcome of the study, emphasis could be refocused on the programs that offer the greatest potential to enable inmates to achieve success when they return to the community.

(Attachment A)

Grand Jury Juvenile Camps - Detention Center Inspection Report Form

GENERAL INFORMATION SECTION --2001

Date _____ Time _____ Phone #_____

Facility Name & Type_____

Address_____ City & Zip _____ Directions _____

_____

Operated By (city / county / other agency) _____ Facility Built _____

Commander / Director _____ Escorted by: _____

Facility Capacity ____ Today's count____ Special Circumstances____ S.H.U. count _____ SHU School_____

% Asian____ %African Am.____ %Hispanic_____ %Caucasian_____ %Other_____ Speak to Youth_____

Juvenile comments below_____ Repeat offenders_____ Facility Phase 1____ 2_____3_____4____ VAP____

Grand Jurors Visiting_____

Sub Committee Reports compiled by: _____

JUVENILE - HOME – CAMP - DETENTION CENTER SECTION

Sign in Log Book____ Fire Inspection Log Book ____ 5 week Food Menu ___ Probation Staff All Shifts _____

Staff Ethnic Mix_____ # Teachers_____ # Classrooms____ 300 Min. Program___ Trade Classes in Place _____

Merit Ladder Program _____Work Exp. Program _____ Youth work on grounds _____ Work in Office ___

Eat a Meal _____ G.J. Sample Food _____ Snacks Available _____ Vending Machines Available _____

Rank Conditions (A-D): Mess Hall _____ Kitchen_____ Medical Station_____ Barracks_____ Bunks_____

Footlocker____ Restroom ____Shower____ Laundry____ Supplies ____ Supply Storeroom ___ Reg. Clothes __

Military Clothes _____ Jail Clothes ____ Books ___ Games ____ Gym _____ Pool _____ Skylights _____

Grounds _____ Paint ____ Graffiti _____ Plumbing _____ Electrical _____ Vitocem paint anti Graffiti ____

Earthquake Drill & Supplies _____ Evacuation Plan Posted _____ Health & Safety____ Fire Clearance _____

Fire Equipment available ____ Nearest Hospital drive time _____ Time for Paramedics _____ Local Police ____

School class conditions_____ Books_____ Computers_____ Discipline_____ Rewards_____ H.S. Grads. _____ GED _____

Committee Notations Rated during inspection tour: PLEASE RANK Conditions: A - excellent, B - above average, C – average, D - sub standard, also include student comments.

(Attachment B)

Grand Jury Jails-Honor Farms-Court Cells Inspection Report Form

GENERAL INFORMATION SECTION – 2001

Date_____ Time_____ Phone #_____

Facility Name & Type_____

Address_____ City & Zip_____

Directions _____

Operated By (city / county / other agency) _____Facility Built _____

Commander / Director _____Escorted by: _____

Facility Capacity _____ Today's count _____ Special 288 _____ k9 _____ k10_____ k11_____ k12_____

LAPD Jails separations Felony _____ Misdemeanor _ _____ Separations within classification _____

Racial % of prisoners at facility today Asian _____ Caucasian _____ African American ____ Hispanic ____

Grand Jurors Visiting_____ Sub Committee Reports compiled by: _____

Jails / Lockup Section Title 15 – 24 Required Info.

Bookings Here ____ Other Facility ___ By Jailer ____ Officer / Detective ____ LASD _____ LAPD ___CSI ____

Property Sheets copy to inmate _____ Filed with property____ Hrs. held this facility ___Translators _____

Telephone 1st call recorded? _____ In sallyport _____ In Cell _____ visual checks posted & logged _____

Collect call $ to inmate welfare fund _____ Restraints used _____ Logged _____ Types used _____

Female jailer ____Male jailer _____ Cell searches by whom _____2nd person attendance _____

Average % Inmates Male ____ Female _____ Juvenile _____ Juveniles printed & logged___ Book/ Form ____

Paying Prisoners _____ Daily _____ Weekends ____ Cost charged _____ Excess $ to prisoner fund ____

Jails Manuel _____ Location _____ Last updated _____ Visual Inspection _____ Fire Manuel _____

Last Inspection _____Visual Inspection____ To send info. ____ Jailer Certificates posted ____ Where _____

Post certificates 40hr._____80hr.____117hr._____170hr._____STC ____ACA Mail____ LAPD____ LASD_____

Type Meals _____Catered ____ Refrigerator ____ Microwave ____ Stove ___Air Packs _____Fire Gear_____

Padded Safety Cells _____ last used _____ logbook _____ Visual inspection of same _____ Vitocem paint_____

Medical on premises_____ Defibrillator____ Paramedics response Time____ logged where____ Noise Levels _____

Evacuation plan posted?_____ Sanitation conditions _____ Enough prisoner separation area _____

Reading Materials _____ Staff Ethnic Mix _____ Other committee walk thru notations _____

FACILITY	ADDRESS	CITY	Zip + 4	PHONE	AREA
Lost Hills - LASD	27050 Agoura Rd.	Agoura	91301-5336	818-878-1808	North
Alhambra Court	150 N Commonwealth	Alhambra	91801-3706	626-308-5314	East
Alhambra PD	211 South First Street	Alhambra	91801-3706	626-570-5168	East
Altadena LASD	780 East Altadena Dr	Altadena	91001-2351	626-798-1131	East
Arcadia PD	250 W Huntington Dr	Arcadia	91007-3401	626-574-5150	East
Santa Anita Race Track	285 W Huntington Dr	Arcadia	91007-3439	626-574-6636	East
Avalon / Catalina Island	215 West Summer Ave	Avalon	90704	310-510-0174	East
Azusa PD	725 N Alameda Ave	Azusa	91702-2562	626-812-3277	East
Baldwin Park PD	14403 East Pacific Ave	Baldwin Park	91706-4226	626-960-1955	East
Bell PD	6326 Pine Avenue	Bell	90201-1221	323-585-1245	South
Bell Gardens PD	7100 S Garfield Ave	Bell Gardens	90201-3253	310-806-7600	South
Bellflower Courts	10025 E. Flower Street	Bellflower	90706-5412	310-288-8001	South
Beverly Hills Courts	9355 Burton Way	Beverly Hills	90210-3265	310-288-1213	West
Beverly Hills PD	464 North Rexford	Beverly Hills	90210-4873	310-285-2125	West
Burbank Courts	300 East Olive Avenue	Burbank	91502-1215	818-557-3490	North
Burbank PD	200 North Third Street	Burbank	91502-1201	818-238-3010	North
Calabasas Courts	5030 N Calabasas Pkwy	Calabasas	91364-1303	818-222-1143	North
Juvenile Camp Gonzales	1301 N Las Virgenes Rd	Calabasas	91302-1905	818-222-1192	North
West Valley Courts	21201 Victory Blvd.	Canoga Park	91303-2830	818-887-4351	North
Carson LASD	21356 S Avalon Blvd	Carson	90745-2213	310-830-1123	South
North Ctny Correctional	29310 The Old Road	Castaic	91384-2905	661-295-7800	North
Industry LASD	150 North Hudson Ave	City of Industry	91744-4430	626-330-3322	East
Claremont PD	570 West Bonita	Claremont	91711-4626	909-399-5411	East
Compton Courts	200 West Compton	Compton	90220-6676	310-603-7386	South
Compton Juvenile Ct	200 West Compton	Compton	90220-6676	310-603-7386	South
Compton LASD	301 S Willowbrook Ave	Compton	90220-3135	310-605-6505	South
Covina PD	444 North Citrus	Covina	91723-2013	626-858-4429	East
Culver City Courts	4130 Overland Avenue	Culver City	90230-3834	310-202-3120	West
Culver City PD	4040 Duquesne Ave	Culver City	90232-2804	310-837-1221	West
Downey Courts	7500 E Imperial Hgwy	Downey	90242-3377	562-803-7149	South
Downey PD	10911 Brookshire Ave	Downey	90241-3847	562-904-2308	South
Los Padrinos Juvenile Ct	7281 Quill Drive	Downey	90242-2001	562-940-8823	South
Los Padrinos Juvenile Hall	7285 Quill Drive	Downey	90242-2001	562-940-8681	South
El Monte PD	11333 East Valley Blvd.	El Monte	91731-3210	626-580-2110	East
Mac Laren Children Ctr	4024 Durfee Avenue	El Monte	91732-2510	626-455-4501	East
Rio Hondo Courts	11234 East Valley Blvd.	El Monte	91731-3241	626-575-4162	East
El Segundo PD	348 Main Street	El Segundo	90245-3813	310-524-2200	South
Gardena PD	1718 West 162nd Street	Gardena	90247-3732	310-217-9606	South
Glendale Courts	600 East Broadway Ave	Glendale	91206-4304	818-500-3527	North
Glendale PD	140 North Isabel Street	Glendale	91206-4313	818-548-4042	North
Glendora PD	150 South Glendora Ave	Glendora	91741-3416	626-914-8278	East
Hawthorne PD	4440 West 126th street	Hawthorne	90250-4402	310-970-7031	South
Hermosa Beach PD	540 Pier St.	Hermosa Bch	90254-3936	310-318-0360	South
Hollywood Courts	5925 Hollywood # 111	Hollywood	90028-5409	213-856-5732	West
Huntington Park Courts	6548 Miles Avenue	Huntington Pk	90255-4318	310-586-6344	South
Huntington Park PD.	6542 Miles Avenue	Huntington Pk	90255-4318	310-584-6254	South
Hollywood Pk Race Track	1050 South Prairie Ave	Inglewood	90301-4120	310-419-1395	West
Inglewood Courts	1 Regent Street	Inglewood	90302-1261	310-419-5297	West
Inglewood Juvenile Hldg	1 Regent Street	Inglewood	90302-1261	310-419-5277	West

Inglewood PD	1 Manchester Blvd.	Inglewood	90301-1750	310-412-5325	West
Lennox LASD	4331 Lennox Blvd.	Inglewood	90304-2367	310-671-7531	West
Irwindale PD	5050 N Irwindale Ave	Irwindale	91706-2133	626-430-2244	East
Juvenile Camp D. Kirby	1500 S McDonnel Ave	Commererce	90022-4823	323-981-4301	East
Crescenta Valley LASD	4554 Briggs Avenue	La Crescenta	91214-3101	818-248-3464	North
Juvenile Camp Afflebaugh	6631 Stephens Ranch Rd	La Verne	91750-1146	909-593-4937	East
Juvenile Camp Paige	6601 Stephens Ranch Rd	La Verne	91750-1146	909-593-4921	East
La Verne PD	2061 Third Street	La Verne	91750-4404	909-596-1913	East
Juvenile Camp Mendenhal	42230 Lake Hughes Road	Lake Hughes	93532-1012	661-724-1213	North
Juvenile Camp Munz	42220 Lake Hughes Road	Lake Hughes	93532-1012	661-724-1211	North
Lakewood LASD	5130 North Clark Avenue	Lakewood	90712-2605	562-866-9061	South
Antelope Valley LASD	1010 West Avenue " J "	Lancaster	93534-3329	661-948-8466	North
Juvenile Camp Jarvis	5300 West Avenue " I "	Lancaster	93536-8312	661-940-4145	North
Juvenile Camp McNair	5300 West Avenue " I "	Lancaster	93536-8312	661-940-4146	North
Juvenile Camp Orizuka	5300 West Avenue " I "	Lancaster	93536-8312	661-940-4144	North
Juvenile Camp Resnick	5300 West Avenue " I "	Lancaster	93536-8312	661-940-4044	North
Juvenile Camp Scobee	5300 West Avenue " I "	Lancaster	93536-8312	661-940-4045	North
Juvennile Camp Smith	5300 West Avenue " I "	Lancaster	93536-8312	661-940-4046	North
Lancaster Courts	1040 West Avenue " J "	Lancaster	93534-3329	661-945-6353	North
Lancaster LASD	501 W Lancaster Blvd.	Lancaster	93534-2515	661-948-8466	North
Lancaster Probation Ct	1040 West Avenue " J "	Lancaster	93534-3329	661-948-6572	North
Mira Loma INS Dentention	45100 N 60th Street West	Lancaster	93536-7607	661-949-3801	North
Lomita LASD	26123 Narbonne Ave	Lomita	90717-2913	310-539-1661	South
Long Beach Courts	415 West Ocean Blvd.	Long Beach	90802-4412	562-491-5919	South
Long Beach Juvenile Prob	415 West Ocean Blvd.	Long Beach	90802-4412	562-491-6181	South
Long Beach PD	400 West Broadway	Long Beach	90802-4401	562-570-7266	South
77th. Street Area LAPD	7600 S Broadway	Los Angeles	90030-2040	213-485-4164	South
Biscailuz Center	1060 North Eastern	Los Angeles	90063-3243	323-881-3636	East
Central Area LAPD	251 East 6th Street	Los Angeles	90014-2116	213-485-3294	East
Central Arraignment Courts	429 Bauchet	Los Angeles	90012-2936	213-974-6281	East
Courthouse Court Services	111 N Hill Street # 628	Los Angeles	90012-3117	213-974-4809	East
Criminal Courthouse	210 West Temple Street	Los Angeles	90012-3012	213-974-4581	East
East LA Courts	214 South Fetterly	Los Angeles	90022-1644	323-780-2026	East
East LA Sheriff	5019 East 3rd Street	Los Angeles	90022-1632	323-264-4151	East
Eastlake Ctn Juvenile Hall	1605 Eastlake Avenue	Los Angeles	90033-1009	323-226-8601	East
Eastlake INS Detn Cntr	1605 Eastlake Avenue	Los Angeles	90033-1009	CLOSED	East
Eastlake Juvenile Courts	1601 Eastlake Avenue	Los Angeles	90033-1009	323-226-8590	East
Eastlake Juvenile Hdg	1601 Eastlake Avenue	Los Angeles	90033-1009	323-226-8590	East
HR Moore Education	7706 Central	Los Angeles	90001-2942	323-586-6055	East
Hollenbeck LAPD	2111 East 1st Street	Los Angeles	90033-3917	213-485-2942	East
Hollywood LAPD	1358 North Wilcox Ave	Los Angeles	90028-8134	213-485-4302	West
Juvenile Justic center	7625 Central	Los Angeles	90001-2952	323-586-6055	South
LA Airport Police	6320 West 96th Street	Los Angeles	90045-5233	310-646-0200	West
LA Coliseum	3939 South Figueroa	Los Angeles	90037-1200	213-765-6711	East
LACMC - USC Jail Ward	1200 North State Street	Los Angeles	90033-1029	213-226-4563	East
LAX Airport Courts	11701 South La Cienega	Los Angeles	90045	310-727-6188	West
LAX Airport Detail	203 World Way	Los Angeles	90045-5807	310-215-2360	West
LAX Sub Station LAPD	802 World Way	Los Angeles	90045-5820	310-646-2255	West
LA Dodger Stadium	1000 Elysian Park Ave	Los Angeles	90012-1112	323-224-1384	East
Men's Central Jail	441 Bauchet Street	Los Angeles	90012-3302	213-974-5058	East
Mental Health Lockup	1150 N San Fernando Rd	Los Angeles	90065-1146	213-974-0146	North

Metropolitan Traffic Ct	1945 South Hill Street	Los Angeles	90007-1413	213744-4101	East
Newton Area LAPD	3400 South Central	Los Angeles	90011-2520	323-846-6547	East
Noreast LAPD	3353 N San Fernando Rd	Los Angeles	90065-1416	213-485-2563	North
Pacific Area LAPD	12312 Culver Blvd.	Los Angeles	90066-6223	310-202-4501	West
Parker Center LAPD	150 N Los Angeles St	Los Angeles	90012-3302	213-485-2547	East
Rampart Area LAPD	2710 West Temple Street	Los Angeles	90026-4724	213-485-2942	West
Southeast Area LAPD	145 West 108th Street	Los Angeles	90061-2001	213-485-6914	East
Southwest Area LAPD	1546 W. M L King	Los Angeles	90062-1744	213-485-2582	South
Staples Arena LAPD	1111 South Figueroa St	Los Angeles	90015-1306	213-742-7444	East
Sybril Brand	4500 E City Terrace Dr	Los Angeles	90063-1010	CLOSED	East
Twin Towers Facilities	450 Bauchet Street	Los Angeles	90012-2907	213-893-5100	East
West L. A. Courts	3000 S Robertson Blvd	Los Angeles	90034-3158	310-558-7758	West
West Los Angeles LAPD	1663 Butler	Los Angeles	90025-3003	310-575-8405	West
Wilshire Area LAPD	4861 West Venice Blvd.	Los Angeles	90019-5664	213-485-4022	West
Century Rgnl Detention	11705 South Alameda	Lynwood	90262-4023	323-257-5100	West
Century Sheriff Station	11703 South Alameda	Lynwood	90262-4023	323-567-8121	West
Juvenile Camp Kilpatrick	427 Encinal Canyon Rd	Malibu	90265-2404	818-889-1353	West
Juvenile Camp Miller	433 Encinal Canyon Rd	Malibu	90265-2404	818-889-0260	West
Malibu Courts	23525 Civic Center Way	Malibu	90265-4804	310-317-1322	West
Manhatten Beach PD	420 15th Street	Manhatten Bch	90266-4607	310-802-5140	South
Harbor Patrol	13851 Fiji Way	Marina Del Rey	90292-6910	310-823-7762	West
Marina Del Rey LASD	13851 Fiji Way	Marina Del Rey	90292-6910	310-823-7762	West
Maywood PD	4317 Slauson	Maywood	90270-2837	323-562-5005	South
Monrovia PD	140 East Lime Avenue	Monrovia	91016-2840	626-256-8500	East
Santa Ana Courts	300 West Maple Avenue	Monrovia	91016-3332	626-301-4066	East
Montebello PD	1600 Beverly Blvd.	Montebello	90640-3932	323-887-1301	East
Edelman Children's Court	201 Centre Plaza Drive	Monterey Park	91754-2142	213-526-6030	East
Monterey Park PD	320 West Newmark Ave	Monterey Park	91754-2818	626-307-1211	East
No. Hollywood LAPD	11640 Burbank Blvd.	No. Hollywood	91601-2316	818-623-4016	North
Devonshire LAPD	10250 Etiwanda Avenue	Northridge	91325-1015	818-756-8283	North
Norwalk Courts	12720 Norwalk Blvd.	Norwalk	90650-3140	562-807-7283	South
Norwalk LASD	12335 Civic Center Dr.	Norwalk	90650-3172	562-863-8711	South
Foothill LAPD	12760 Osborne	Pacoima	91331-3331	818-756-8861	North
Palmdale LASD	1020 East Palmdale Blvd.	Palmdale	93550-4749	661-267-4300	North
Palos Verdes Estates PD	340 Palos Verdes Dr Wes	Palos Verdes	90274	310-378-4211	West
Pasadena Courts	200 North Garfield	Pasadena	91101-1728	626-356-5266	East
Pasadena Courts	300 E Walnut Room # 101	Pasadena	91101-1566	626-356-5570	East
Pasadena Juvenile Prob.	300 E Walnut - 6th Floor	Pasadena	91101-1566	626-356-5458	East
Pasadena PD	207 North Garfield Ave	Pasadena	91101-1728	626-744-4616	East
Pasadena Rose Bowl	1001 Rose Bowl Drive	Pasadena	91103-2813	626-577-3159	East
Pico Rivera LASD	6631 South Passons Blvd.	Pico Rivera	90660-3645	562-949-2421	South
LAC Fairgrounds	1011 West McKinley	Pomona	91766	909-620-2186	East
Pomona Courts	350 West Mission Blvd.	Pomona	91766-1607	909-620-3266	East
Pomona Juvenile Ct	400 Civic Ctr. Plaza # 705	Pomona	91766-3201	909-620-3266	East
Pomona Juvenile Prob	400 Civic Ctr. Plaza # 403	Pomona	91766-3201	909-620-4272	East
Pomona PD	490 West Mission Blvd.	Pomona	91766-1608	909-620-2131	East
Redondo Beach LASD	117 West Torrance Blvd.	Redondo Bch	90277-3633	310-318-8700	South
Redondo PD	401 Diamond Street	Redondo Bch	90277-2836	310-318-0616	South
West Valley LAPD	19020 Van Owen Street	Reseda	91335-5114	818-756-8543	North
Juvenile Camp Rockey	1900 N Sycamore Cyn Rd	San Dimas	91773-2646	909-599-2391	East
San Dimas LASD	122 N San Dimas Ave	San Dimas	91773-2646	909-599-1261	East

Juvenile Camp Holton	12653 N Little Tujunga Cy	San Fernando	91342-6311	818-896-0571	North
San Fernando Courts	908 East Third Street	San Fernando	91340-2934	818-898-2401	North
San Fernando PD	910 First Street	San Fernando	91340-2928	818-898-1255	North
San Gabriel PD	625 So. Delmar	San Gabriel	91776-2409	626-308-2840	East
San Marino PD	2200 Huntington Drive	San Marino	91108-2639	626-300-0720	East
Harbor Area LAPD	2175 John Gibson Blvd.	San Pedro	90731-1501	310-548-7605	South
San Pedro Courts	505 South Centre Street	San Pedro	90731-3332	310-519-6026	South
Santa Monica Courts	1725 Main Street	Santa Monica	90401-3261	310-260-3515	West
Santa Monica PD	1685 Main Street	Santa Monica	90401-3248	310-458-8495	West
Juvenile Camp Scott	28700 N Bouquet Cyn Rd	Saugus	91350-1220	661-296-8500	North
Juvenile Cap Scudder	28750 N Bouquet Cyn Rd	Saugus	91350-1220	661-296-8811	North
Sierra Madre PD	242 W Sierra Madre Blvd.	Sierra Madre	91024-2312	626-355-1414	East
Signal Hill PD	1800 East Hill Street	Signal Hill	90806-3716	562-989-7200	West
South Gate Courts	8640 California Avenue	South Gate	90280-3004	323-563-4031	South
South Gate PD	8620 California Avenue	South Gate	90280-3004	323-563-5457	South
South Pasadena PD	1422 Mission Street	S Pasadena	91030-3214	626-403-7270	East
Barry Nidorf Juvenile Ct	16350 Filbert Street	Sylmar	91342-1002	818-364-2111	North
Barry Nidorf Court Hldg	16350 Filbert Street	Sylmar	91342-1002	818-364-2035	North
B. Nidorf Juvenile Hall	16350 Filbert Street	Sylmar	91342-1002	818-364-2001	North
Temple LASD	8838 E Las Tunas Drive	Temple City	91780-1820	626-285-7171	East
Torrance Courts	825 Maple	Torrance	90503-5018	310-222-3345	South
Torrance PD	300 Civic Center Dr.	Torrance	90503	310-328-3456	South
Juvenile Camp Routh	12500 Big Tujunga Cyn	Tujunga	91042-1140	818-352-4407	North
Sheriff Parks Sub Sta	1000 Universal Center Dr	Universal City	91608-1008	818-622-9546	North
Santa Clarita Valley	23740 Magic Mtn Pkwy	Valencia	91355-2102	661-255-1121	North
Valencia - Newhall Ct	23747 West Valencia Blvd	Valencia	91355-2105	661-253-7331	North
Valencia Magic Mt Hldg	26101 Magic Mtn Pkwy	Valencia	91355-1052	818-367-2271	North
Valencia Probation Ct	23759 W Valencia Blvd	Valencia	91355-2105	661-253-7278	North
Van Nuys Courts	144 Erwin St. Mall	Van Nuys	91401	818-374-2560	North
Van Nuys Courts	6230 Sylvan	Van Nuys	91401	818-374-2121	North
Van Nuys PD	6240 Sylmar	Van Nuys	91401	818-756-8347	North
Vernon PD	4305 Santa Fe Avenue	Vernon	90058-1714	323-587-5171	South
Walnut LASD	21695 East Valley Blvd.	Walnut	91789-2019	909-595-2264	East
West Covina Courts	1427 W. Covina Parkway	West Covina	91790-2728	626-813-3255	East
West Covina PD	1444 Garvey Avenue	West Covina	91791	626-814-8556	East
West Hollywood LASD	720 N San Vincente Blvd	Wt Hollywood	90069-5021	310-855-8850	West
West Los Angeles Ct	1633 Purdue Avenue	West L. A.	90025-3117	310-312-6500	West
Whittier Courts	7339 Painter	Whittier	90602-1852	562-907-3171	East
Whittier Juvenile Prob	7339 Painter	Whittier	90602-1852	562-907-3171	East
Whittier PD	7315 Painter	Whittier	90602-1852	562-945-8262	East

Juvenile Facilities

Juvenile Facilities	Sign-in Log	Fire Log	Food Log	Facility Capacity	Today's Count	Special Cases & ICU	S.H.U. Count / ICU Count	S.H.U. School	% Asian	% African Am.	% Hispanic	% Caucasian	% Other	Speak with Youth	Repeat Offenders	Staff Supervision	Good Ethnic Mix	Teachers	Classrooms	300 Min. Education	Trade Class	Merit Class Ladder	Work Exp. Class	GJ have meal	Snacks	Mess Hall	Kitchen	Medical Station	Barrack, cottage, dorm	Bunks	Footlockers	Restrooms	Showers
Barry Nidorf Juvenile Courts				35	34																											
Barry Nidorf Juvenile Hall	X	X	X	626	666	X		X		35	35	20	10		40	447	X	40	31	X		X			X	B	A	B	B	B		A	A
Eastlake Detention Center	X	X	X	438	641		40	X	2	34	58	5	1	X	60	364	X	39	33	X				X	X		B	B	C	C	C	D	D
Eastlake Juvenile Courts				??	107																											
Eastlake Juvenile Facility INS				0	0																											
Juvenile Camp Afflerbaugh	X	X	X	116	124				2	35	60	1	2		X	32	X	11	14	X		X	X		X	B	B	B	C	C	C	C	D
Juvenile Camp Dorothy Kirby	X	X	X	100	96	X	19		1	40	40	19		X	X	130	X	9	7	X	X	X	X		X	B	A	A	C	C	C	B	B
Juvenile Camp Gonzalez	X	X	X	125	129	X	20	8	2	13	80	5		X	X	49	X	8	7	X		X	X		X	B+	A	A	B-	C	B	C-	C-
Juvenile Camp Holton	X	X	X	135	126	X	20	X	1	28	70	1		X	X	36	X	7	6	X		X			X	B	B	A	B	C	C	D	D
Juvenile Camp Jarvis	X	X	X	120	119	X			2	45	55	6	2	X	X	36	X	44	23	X	X	X	X	X	X	NA	B+	B+	B	B	C	C	C
Juvenile Sports Camp Kilpatrick	X	X	X	124	125	X	19	4	2	60	32	3	3	X	X	61	X	7	7	X			X	X	X	B	B+	B	C-	B	B	C	C
Juvenile Camp McNair	X	X	X	120	109	X			2	45	55	6	2	X	X	36	X	44	23	X	X	X	X	X	X	NA	B+	B+	C	C	C	C	C
Juvenile Camp Mendenhall	X	X	X	110	108				10	40	40	10			40	47	X	12	6	X		X	X		X	B	B	B	C	C	D	D	D
Juvenile Camp Miller	X	X	X	115	118	X	4	X		28	72			X	X	42	X	7	7	X		X	X	X	X	B	B+	B+	B-	B-	C	B-	B-
Juvenile Camp Munz	X	X	X	110	107				5	15	70	5	5		X	33	X	6	7	X		X	X		X	B	B+	B	C	C	D	D	D
Juvenile Camp Onizuka	X	X	X	120	98	X			2	45	45	5	3	X	X	36	X	44	23	X	X	X	X	X	X	NA	B+	B+	B	B	C	B	B
Juvenile Camp Paige (fire)	X	X	X	116	124		2		3	40	55	1	1		X	25	X	11	14	X			X	X	X	B	A	B	B	C	C	B	C
Juvenile Camp Resnick	X	X	X	120	105	X			2	45	55	5	3	X	X	36	X	44	23	X	X	X	X	X	X	NA	B+	B+	C	C	C	C	C
Juvenile Camp Rocky	X	X	X	125	134	X	10	X	3	30	63	3	1		X	55	X	8	6	X			X		X	B	B	B	C	C	C	C	D
Juvenile Camp Routh (fire)	X	X	X	96	104				5	20	70	5		X	X	38	X	5	2	X			X		X	B	B	B	B	B	C	D	D
Juvenile Camp Scobee	X	X	X	120	104	X			2	45	55	6	2	X	X	36	X	44	23	X	X	X	X	X	X	NA	B+	B+	C	C	C	C	C
Juvenile Camp Scott (females)	X	X	X	113	100				3	30	60	3	4	X	X	37	X	6	7	X	X	X	X		X	C	C	B	C	C	C	C	C
Juvenile Camp Scudder	X	X	X	118	115				8	30	60	2			X	27	X	7	5	X	X	X	X		X	C	C-	B	C	C	C	C	C
Juvenile Camp Smith	X	X	X	120	107	X			4	45	45	4	2	X	X	36	X	44	23	X	X	X	X	X	X	NA	B+	B+	B	B	C	C	C
Juvenile Courts																																
Juvenile Justice Center																																
Los Padrinos Juvenile Courts																																
Los Padrinos Juvenile Hall	X	X	X	800	672	X	43	X	20	40	40				X	471	X	29	24	X						B	B	A	C	C	D	C	B
MacLaren Children's Shelter																																
Mental Health Courts / Juv. Hold																																
Pomona Juvenile Courts				60	21				10	25	60	5		X	X	2																

SHU - Special Housing Unit

A - Excellent

B - Above Average

C - Average

D - Below Average

F - Failure

South Area Facilities	Capacity	Today's Count	Bookings Done Here	Bookings Done Elsewhere	By Jailer	By Officer	LASD	LAPD	CSI	Property Sheet to Inmate	With Property	Hours Held Here	Translators	Record First Call	Sallyport	Cell	Visual Checks	Collect Phone Call Monies to IM	Restraints Used	Logged	Female Jailers	Male Jailers	Two Person Cell Search	Percent Men	Percent Women	Percent Juveniles
77th Street Area LAPD	180	63	X				X			X	X	48	X			X	X	X			X	X	X	70	20	10
Bell Gardens PD	25	2	X		X					X	X	4	X			X	X				X	X	X	80	20	
Bell PD	16	0	X		X				X	X	X	48	X			X	X				X	X	X	95	5	
Bellflower Courts	2	0		X		X	X			X	X	4	X			X					X	X	X	80	20	
Bellflower LASD Sub Station	4	0		X			X			X	X	4	X			X	X	X			X	X	X	80	20	
Carson LASD	69	21	X				X			X	X	72	X			X	X	X			X	X	X	85	15	
Compton Courts	435	100	X				X			X	X	8	X			X	X	X			X	X	X	110	15	2
Compton Juv. Lockup	30	0																								
Compton PD - LASD	30	0										24	X									X	X			
Downey Courts	253	93	X				X			X	X	8	X			X	X	X			X	X	X	80	20	
Downey PD	25	1	X		X				X	X	X	24	X			X	X	X	X	X	X	X	X	70	20	10
El Segundo PD	17	0	X		X			X		X	X	48	X			X	X				X	X	X	70	30	
Gardena PD	38	3	X		X					X	X	96	X			X	X				X	X	X	98	1	1
Harbor Area LAPD	54	5	X		X					X	X	48	X			X	X				X	X	X	80	3	7
Hawthorne PD	26	18	X		X					X	X	48	X			X	X	X			X	X	X	80	25	5
Hermosa PD	14	1	X					X		X	X	48					X				X	X	X	95	5	
Huntington Park Courts	79	18	X				X			X	X	8	X			X	X	X			X	X	X	95	5	
Huntington Park PD	32	3	X		X					X	X	72	X			X	X	X			X	X	X	99	1	
Lakewood LASD	48	15	X				X			X	X	72	X			X	X	X			X	X	X	90	10	
Lomita LASD	28	0	X				X			X	X	72	X			X	X	X			X	X	X	80	10	10
Long Beach Courts	280	112	X				X			X	X	4	X			X	X	X			X	X	X	80	20	
Long Beach Juvenile Probation	35	8																	X	X						
Long Beach PD	256	6	X		X			X		X	X	72	X			X	X		X	X	X	X		75	25	
Manhattan Beach PD	26	0	X		X			X		X	X	72	X		X	X	X		X		X	X	X	90	10	
Maywood PD	9	6	X					X		X	X	72	X			X	X	X			X	X	X	90	5	5
Newton Area LAPD	36	1										6	X											85	15	
Norwalk Courts	222	81	X				X			X	X	8	X			X	X	X			X	X	X	90	10	
Norwalk LASD	55	14	X				X			X	X	120	X			X	X	X			X	X	X	90	10	
Pico Rivera LASD	36	9	X				X			X	X	72	X			X	X	X			X	X	X	80	20	
San Pedro Courts	57	6	X				X			X	X	6	X			X	X	X			X	X	X	90	10	
Southwest Area LAPD - MLK	55	6	X		X			X		X	X	48	X			X	X	X				X	X	100		
Southeast Area LAPD-108th St.	50	4	X		X			X		X	X	120	X			X	X				X	X	X	100		
Vernon PD	19	2	X		X			X		X	X	24	X			X	X				X	X	X	90	10	10

JAILS COMMITTEE

Inmate Welfare Fund
Los Angeles County Sheriff's Department

BACKGROUND

The Inmate Welfare Fund (IWF) is a special fund, as designated by the Board of Supervisors. The designation of a special fund gives the Inmate Welfare Fund privileges not accorded standard budgets. In this case, the fund is allowed a year-to-year carry over balance.

By definition, the IWF is to be used to provide services and programs to the inmates and correctional facility repair and enhancements. The IWF represents millions of dollars generated as a result of the use of telephones by the inmates, purchases made at the jail store, hobby store and barber services, etc. The IWF and its policies were reviewed by the 1999-2000 Los Angeles County Grand Jury. Recommendations were made by that body to the Sheriff's Department to develop an expanded budget, to manage the monies in accordance with strict business procedures by writing definitive policies and by using standard accounting practices.

OBJECTIVES

The Los Angeles County Civil Grand Jury 2001-2002 decided to review and evaluate the IWF based on recommendations made by the Los Angeles County Grand Jury 1999-2000. The original review found the IWF policies to be lacking. However, an investigation conducted by the 1999-2000 Grand Jury found no malfeasance in the application of the monies as measured against the mandate. The objective of this grand jury was to determine what recommendations made by the previous grand jury were implemented.

METHODOLOGY

Members of the Jails Committee reviewed information and recommendations from the 1999-2000 final report, met with the fund managers responsible for administering the IWF, reviewed an external audit initiated by the department obtained and reviewed the new policy manual entitled Inmate Welfare Commission Fiscal Handbook, dated March, 2001.

FINDINGS

The 1999-2000 Grand Jury investigated the procedural and fiscal operations of the IWF. That jury made nine recommendations to the Sheriff's Department.

Listed below are the recommendations and the Sheriff's Department responses.

Recommendation #1 – The Inmate services Unit, with the involvement of the IWF Commission, should develop a strategic plan.

> Sheriff's response – A two-year strategic plan was developed including a mission statement, objectives and commission strategies.

Recommendation #2 – IWF should review all funded programs at least annually to assess their overall effectiveness.

> Sheriff's response – Each pilot project was analyzed and evaluated at the end of the test period. In addition, each year a report will be provided on all existing programs.

Recommendation #3 – IWF should invest in the future by targeting a percent of available annual funding for innovative pilot programs.

> Sheriff's response – A portion of the fund was to be set aside for innovative pilot programs, however, no specific percentage was stated. In 2000-2001 budget, $1.5 million was set aside; in 2001-2002 no set-aside was found in the budget.

Recommendation #4 – The Sheriff's Department should target definable subsets of the inmate population for selection and participation in programs developed specifically for them.

> Sheriff's response – There was no specific policy to identify any subset of inmates to be included in pilot programs, new or old.

Recommendation #5 – The IWF should measure and evaluate the success of IWF funded programs.

> Sheriff's response – By policy, each new program was to be evaluated for overall effectiveness at the end of the test period. On-going programs were to be assessed annually.

Recommendation #6 – The Inmate Services Unit should initiate project-tracking procedures for all IWF funded projects.

> Sheriff's response – A system for reporting from divisions within the department that used IWF monies has been implemented and all programs were to be reviewed annually and presented to the commission.

Recommendation #7 – The IWF Commission should review and approve all expenditures made through the fund.

Sheriff's response – The commission was empowered to review expenditures from the inmate programs portion of the fund only (51% of the fund). Facility maintenance issues addressed by the IWF (49% of the fund) were reviewed by the facility manager, county counsel and the budget authority.

Recommendation #8 – The Inmate services Unit should schedule annual financial audits of the IWF that are performed by or under the guidance of the Auditor-Controller.

Sheriff's response – the IWF was audited in October, 2001 by an outside entity. Changes in the IWF procedures were put in place in March, 2001.

Recommendation #9 – The Sheriff's Department should proactively pursue a national and international leadership role in inmate program innovations.

Sheriff's response – The IWF manual encouraged commissioners and jail staff to " . . . attend presentations, conferences and training throughout the country . . . ." to research new inmate programs in other systems. In addition the Large Jail Network and the Internet were to be used as a tool to search for new programs.

The Jury found the IWF to be compliant with existing laws and policies. Eight of nine 1999-2000 Grand Jury recommendations were implemented.

It should be noted that the IWF is well run. The administrators of the fund are open to scrutiny, willing to listen, and amenable to adjust procedures in order to make the fund more efficient.

The Penal Code and department policies offer the Sheriff wide fiscal latitude in the disbursement of IWF funds, especially on the facility maintenance side. Since the IWF has the designation of Special Fund, the annual budget need not be spent and monies can be carried over. The discretion allowed the Sheriff may appear arbitrary, however, it is necessary to accomplish long-term goals, smooth the ups and downs of a cyclic economy and provide inmates with the most useful services.

JAILS COMMITTEE

INMATE WELFARE FUND
Los Angeles Sheriff's Department

RECOMMENDATIONS

68. The Jails Committee recommends to succeeding grand juries that they monitor the IWF for compliance with the law and its own policies.

69. The Jails Committee recommends that succeeding grand juries scrutinize the IWF expenditures (or lack thereof) to see that the accumulation of monies is not excessive and monies are being prudently applied to meet the Sheriff's mandate of providing services to the inmates.

70. The Jails Committee recommends that the Sheriff's Department refine the procedures manual by including a specific percentage of the IWF balance to be set aside in each budget year for new pilot programs.

71. The Jails Committee recommends that the Sheriff's Department state in the Welfare Commission Fiscal Handbook that not only will 51% of the IWF balance be budgeted, but also spent on inmate programs each year. If any portion of the inmate program money is not spent, it should be carried over to the next fiscal year as funds for inmate programs only. It should not be co-mingled with facility maintenance funds.

JAILS COMMITTEE

Los Angeles County Sheriff's Department
Biscailuz Recovery Center
Bridges to Recovery Domestic Violence Program
Limited Scope Management Audit

BACKGROUND

The Los Angeles County Civil Grand Jury 2001-2002 invited Sheriff Lee Baca to speak to the grand jury regarding the state of the Sheriff's Department. During his appearance before the grand jury, the sheriff spoke of the low recidivism rate associated with the Domestic Violence Intervention program offered at the Biscailuz Recovery Center (BRC). The grand jury, subsequent to the sheriff's jury appearance, toured the facilities, met with the staff at the BRC and observed the Domestic Violence Intervention program in progress.

The jury was impressed with the physical plant, the Domestic Violence Intervention program and especially the enthusiasm of the staff. The grand jury observed many positive and notable social attributes such as mutual respect between the inmates and staff, positive interaction between the diverse inmate population, minimal security problems, and the absence of graffiti, not seen in any other detention facility. Based on these observations, the grand jury wanted to explore the possibility of supporting the expansion of program participation to the facility's capacity. However, in order to lend credence to the low recidivism rate claimed (a key element in lending the jury's support), an independent auditing firm was engaged to review the Domestic Violence Intervention program from intake to post graduation.

The auditor's findings with regards to the program were disappointing. The recidivism rates stated by the department could not be validated due to a number of factors. One such factor was the inability to capture supportive statistical information.

The jury felt that the program might be worthy of support, based on the jury's positive observations. However, the recommendations of the grand jury to the Sheriff's Department need to be implemented in order to quantify the claims of a notably low recidivism rate (a measure of program success) before any support could be offered.

The following audit enumerates the findings of the limited scope management audit performed by the independent auditor, as edited by the grand jury.

INTRODUCTION

The Harvey M. Rose Accountancy Corporation (HMR) is pleased to present this *Limited Scope Management Audit of the Los Angeles County Sheriff's Department Biscailuz Recovery Center, Bridges to Recovery Domestic Violence Program.* This management audit was requested by the 2001-02 Los Angeles County Civil Grand Jury to:

1. Develop a profile of program participants so that the Grand Jury can obtain a better understanding of the number and characteristics of Biscailuz Recovery Center (BRC), domestic violence program participants.

2. Provide an analysis of program costs to determine if resources are being used effectively.

3. Review the appropriateness of outcome measures that are being assessed by the Sheriff's Department.

4. Provide an independent assessment of program completion rates and recidivism rates for program participants.

The Grand Jury is granted authority to investigate the activities of local government agencies by Section 925 of the California Penal Code. The use of experts to assist the Grand Jury in these investigations is permitted by Section 926 of the same code. The request for this management audit was made by the 2001-02 Los Angeles Civil Grand Jury after its own initial investigation of BRC program effectiveness.

STUDY SCOPE AND METHODOLOGY

The initial scope of the study was developed to describe, assess and evaluate the domestic violence treatment programs provided at BRC. After our pre-audit survey activities were completed, we advised the Grand Jury that there are actually two distinct programs located at the BRC facility: (1) the "Bridges to Recovery" Domestic Violence Intervention and Recovery Program, which provides domestic violence treatment and education services to approximately 60 inmates at the facility; and, (2) the IMPACT Drug Treatment Program, which provides treatment services to inmates with identified substance abuse problems (typically, IMPACT program participants are referred to BRC from the County's drug courts).

Shortly after notifying the Grand Jury of these distinctions, we were instructed to assess the Bridges to Recovery Domestic Violence Program only. Therefore, discussion of the IMPACT program services provided at BRC is limited to the collateral drug counseling services that are provided to Bridges to Recovery domestic violence program participants by IMPACT program contractors.

Based on the original work plan, and the clarification of project scope received from the Grand Jury, the BRC domestic violence program management audit was to answer the following questions:

- What are the number and profile of program participants?
- How do program participants differ from other LA County inmates who have been convicted on domestic violence charges, but do not participate in the program?
- What is the program cost per inmate? How does the cost compare with those for the general inmate population?
- Is the Sheriff's Department utilizing reasonable and measurable indicators of program success?
- What is the recidivism rate of those who have completed the program? Of comparable inmates who have not participated in the program?
- What does general literature suggest about the potential success of a program with the characteristics of the Bridges to Recovery Program?
- Are any changes needed to improve the effectiveness and/or lower the costs of the program?

In order to answer these questions, initial meetings were held with Los Angeles County Sheriff's Department (LASD) and Hacienda La Puente School District (HLPSD) managers to describe the study scope, purpose and authority of the Grand Jury; interviews were conducted with personnel from the LASD and HLPSD to obtain an understanding of the program; and, available County and School District program documentation was reviewed. In addition, two outcome studies published by the Sheriff's Department were evaluated, and limited samples of inmate and student records that are maintained by the agencies were conducted.

Based on these management audit activities, we developed the findings and recommendations contained in this report. However, our ability to accomplish original Grand Jury objectives were hampered because neither the LASD nor the HLPSD responded to our requests for participant documentation in a timely manner. As a result, many of our findings and recommendations relate to the need for procedural changes and better program documentation if the County is to obtain a reliable evaluation of the program at some future date. Our other findings related to program effectiveness are qualified, due to delays in receiving responses from the involved agencies and the Grand Jury's own statutory time limits for completing the management audit. This is discussed more fully, below.

The limited scope management audit was conducted in accordance with *Government Auditing Standards, 1994 Revision,* by the Comptroller General of the United States, U.S. General Accounting Office. As a result, certain procedures were followed to ensure the accuracy of the information contained in the report, and the reasonableness of the findings, conclusions and recommendations contained herein.

LIMITATIONS

During the three-month course of conducting this audit, there were a number of limitations that prevented a comprehensive review of data maintained by the LASD and HLPSD. As a result, program objectives were not fully accomplished.

Delays receiving certain key data from both agencies contributed most directly to our inability to accomplish these objectives. Further, because the two agencies (1) do not maintain a consolidated database of participant data, or (2) utilize appropriate internal control procedures to ensure that disparate database systems and other records are reconciled, the integrity of participant data is uncertain.

During the period of the delay, the Sheriff's Department's management was unresponsive to our requests for information and raised certain concerns regarding record confidentiality, requiring the intervention of legal counsel for the Grand Jury. In fact, we did not obtain required inmate records from the Sheriff's Department until we requested the legal counsel for the Grand Jury to make a demand. Understanding that the Sheriff's records of inmate participation were incomplete, we also asked the Hacienda La Puente School District to provide us with a database of BRC student records. As with the Sheriff, the receipt of student records from the HLPSD was delayed until after we involved legal counsel for the Grand Jury.[1]

Because detailed inmate and student records were not received until April, we were unable to test the validity of the data that was provided, and were only able to conduct a very limited review of program outcomes. In addition, we were unable to perform other critical analyses that we believe are essential for determining Bridges to Recovery program success. For example, we were unable to select a comparison group to determine whether there are recidivism outcome differences between participants and non-participants of the program. We also were unable to work with the Los Angeles County Probation Department to obtain an independent assessment of participant and non-participant recidivism, or to assess the impact that post-release domestic violence treatment services might have on BRC program outcomes.

As will be discussed in this report, it is our opinion that the recidivism studies conducted internally by the Sheriff's Department are of limited value. In addition, because our audit analysis is based on interviews and secondary data analysis of the limited information provided by the LASD and HLPSD, we are unable to provide the Grand Jury with an unqualified opinion of program effectiveness.

[1] It should be noted that the database was never received from the School District, due to management concerns about the integrity of the record. Instead, hard copy student records were provided, which required our staff to conduct original entry of a sample of key program data elements in order to glean relevant information for the study.

1. PROGRAM CURRICULUM AND OPERATIONS

- **Although there is a general BRC Domestic Violence Program goal, reasonable and measurable, overall program objectives need to be developed; as well as specific guidelines and procedures for determining (a) how that overall goal will be achieved, and (b) how inmates and program staff know when the goal has been met. Objective criteria for successfully completing the program need to be developed and communicated to inmates and staff. Program outcomes need to be validated with pre- and post-testing of the participating inmates.**

- **A formal, state-approved course curriculum has been developed for the Bridges program for each of the seven class groupings. The course description, class outlines, formal descriptions of goals and objectives and lesson plans are well documented; however, many of the course objectives are too broad and not measurable. Also, there is a need for a formalized process and documentation for determining if a student has successfully met all program objectives, and it is unclear how instructors know if students have successfully met class objectives.**

- **There is no documentation or process for determining whether all potential BRC candidates are screened, or how many potential candidates qualify for the program. The Sheriff's Department needs to develop tools to systematically assess and record admission decisions so that the domestic violence program can be adapted to inmate treatment needs.**

- **Formal criterion and processes for selection need to be developed. The bulleted list of selection criteria created for the audit, needs to include all criteria, including the offenses accepted. Program participation should be limited to individuals convicted of domestic violence related charges only so that selection subjectivity by the intake officer is controlled. The selection criteria based on the time remaining on the inmate sentence needs to be formalized and more consistently applied. A formal and thorough assessment process needs to be developed by the HLPSD program staff to determine the appropriateness of each program participant and obstacles that may prevent effective treatment.**

- **The Sheriff's Department needs to develop adequate tools to systematically assess and record admission decisions, so that the BRC Bridges program can be adapted to the domestic violence needs of the correctional population. In addition, the HLPSD staff needs to be formally involved in the selection process to help determine the pool of potential participants and the disqualification.**

- **The BRC facility orientation process, conducted by the Sheriff's Department is unstructured and not formalized, and the thoroughness of the orientation appears to be based on the preferences of the individuals conducting the orientation, guided by a brief checklist of items to cover. Formalized materials need to be developed so that each inmate receives the same level of orientation. The Bridges to Recovery program expectations and criteria should be incorporated into the Sheriff's orientation process, creating a single, co-lead orientation between the Sheriff and HLPSD. A more in-depth assessment process can be conducted solely by HLPSD for determining program placement, limitations to program success, etc. Also, formal training for anyone who may conduct the orientation needs to be developed and implemented consistently for both the Sheriff's staff and HLPSD.**

- **The vast sentencing window of 6 weeks to 3 months should be limited to be as close to 6 weeks as possible, given the fact that the course is 6 weeks long. This would allow for additional inmates to participate in the program, rather than fewer inmates participating in the program for longer than the curriculum requires. The need for work trustees to run the facility should be analyzed to determine if the current program inmates could run the facility rather than accepting inmates with 3 months left in order make them trustees after they have graduated. This appears to be an inefficient use of program bed space.**

- **A more extensive and formal process for transitioning inmates into the community needs to be developed and supported by more than one part-time counselor. A curriculum should be developed and formally implemented, and contact with the LASD Community Transition Unit and Probation Department are essential if inmates are to successfully transition to the community.**

PROGRAM OVERVIEW

The Biscailuz Recovery Center (formerly the Biscailuz Center jail) officially reopened on July 15, 1999 to "assist inmates in making a successful transition back to the community upon their release from jail." The Biscailuz Recovery Center (BRC) is a low-security facility designed to "provide goal-oriented inmates the opportunity to rehabilitate themselves through the strict regimen of the programs offered." The two programs currently in operation are the IMPACT Drug and Alcohol Treatment Center (a 60-bed program) and the Domestic Violence Intervention and Recovery Services (a 60-bed program), which is the program focus of this audit.

The Domestic Violence Intervention and Recovery Services program is a cooperative effort between the Los Angeles County Sheriff's Department and the Correctional Education Division of the Hacienda-La Puente Unified School District. These two distinct entities, the Sheriff's

Department and the School District approach their roles at BRC differently. The Sheriff's staff approaches their role from the correctional standpoint of discipline and staff and inmate safety; while the School's role is to implement the course curriculum in order to teach inmates ways to reduce domestic violence tendencies. The overall goal of the program is to:

> "dismantle and eliminate the offender's violent behavior traits and instill in the inmate knowledge of one's self, proper communication techniques and appropriate social skills."

The program is strict and regimented with a number of rules and regulations and a zero tolerance policy implemented by both the Hacienda School staff and the Sheriff's Correctional staff. The inmates spend their time either in class or on work detail. The program is theoretically based on a six-week domestic violence curriculum; however, the length of time for each participant varies.

PROGRAM CURRICULUM AND SERVICES

The Bridges to Recovery Domestic Violence Program course curriculum was developed by Hacienda La Puente Correctional Education Division. According to Hacienda, the course curriculum is continuously updated as new theories and instructional strategies are discovered. The program is based on a 30-hour week (six hours/day, five days/week) where 50% is domestic violence programming, 25% is substance abuse counseling and 25% is parenting classes. The curriculum is based on a total of 180 hours of class time, which does not include homework assignments. Currently, the program consists of the following seven major subject areas:

- Personal Relationships
- Parenting
- Drug Education
- AIDS Education
- Beat the Street
- Job Skills
- Academics

Each of the subject areas has a required number of classes the student must attend in order to successfully complete the Bridges program (see Attachment 1). Some of the subject areas also have a defined set of Goals and Objectives; however, many of the objectives have quite broad and objectives that are not measurable, such as "become a better parent". It is unclear how the instructor of the class determines if the student has achieved the class goals and objectives. The existing class outlines and lesson plans have detailed information on what to teach and how to teach it; but not about how to measure if what was taught was learned. HLPSD reported that pre- and post-testing exists for HIV/AID and Drug Education; and that pre- and post-testing should be developed for all course areas to formally determine if objectives are met. The audit team did not evaluate the pre- and post-testing that does exist. It is also unclear how some of the course descriptions and the goals and objectives listed in Attachment 2 tie into the class lists for Personal Relationships, Drug Education, Parenting, Beat the Street, Job Skills, AIDS Education and Academics.

The BRC Domestic Violence Program appropriately links substance abuse and domestic violence treatment throughout the curriculum. BRC staff estimate that 85% of Domestic Violence offenders also have substance abuse issues. A number of studies have shown that link as well, including a *1997 National Institute of Justice Report*: *Drugs, Alcohol and Domestic Violence in Memphis*, where "almost all assailants had used drugs or alcohol during the day of the assault and two-thirds had used a dangerous combination of cocaine and alcohol;" and, a *Crime and Justice Research Institute Report: Drug and Alcohol Abuse in Domestic Violence and Its Treatment*, which showed that a "conservative estimate of 40 to 50 percent of defendants in domestic violence cases used alcohol or other drugs of abuse at or near the time of the precipitating incidents". Analyses of domestic abuse cases and restraining orders suggest that between 71 and 85 percent of domestic violence cases involve batterers who are substance abusers. The link between Drug Education and Domestic Violence programming is necessary.

In addition to the Bridges course curriculum, HLPSD added an informal process of working with the inmates to transition them out of custody. This process includes a counselor meeting individually with each inmate prior to their departure from BRC and determining what their needs will be once they return home. A sample of the Correctional Education Division Support Services Form is included as Attachment 3. This informal process is an excellent addition to the overall program; but it needs to be much more extensive and formalized so that each inmate receives the proper amount of time to work on their transition out of custody. Currently, only one counselor is assigned to meet with each inmate. This counselor is only on-site twice a week. This component of the program should be expanded to incorporate the Community Transition Unit and contact with the inmate's probation officer, at the very least.

The part-time counselor also offers Alumni Class Participation every Monday night for those who graduate from BRC. The participation in these classes is very limited and its effectiveness cannot be determined.

ENTRY CRITERIA AND THE SELECTION PROCESS

According to the entry criteria for housing and participation at BRC Domestic Violence Intervention and Recovery Services, there are three ways that inmates are accepted into the Domestic Violence Program

1. An in-custody defendant may be remanded to BRC from court. Some judges who hear domestic violence cases are familiar with the BRC program and request to have their defendants attend the classes.

2. Miscellaneous requests are generated by inmates, their family members, attorneys, chaplains, or counselors.

3. Once a month, the program liaison officer at BRC requests a list from the Inmate Reception Center (IRC) of all inmates in custody for domestic violence related crimes. Each inmate is evaluated to determine if he would be appropriate for program participation. The majority of inmates are selected through this process.

The list generated from IRC is based on criteria provided by the Intake Officer at BRC. This initial criteria includes the following specific Penal Code offenses:

- 273.5 (domestic violence)
- 273E (domestic violence)
- 242 (battery on spouse)
- 666 (petty theft with priors)
- Violation of Probation

The 666 offense type participants are reportedly enrolled when the officer knows the petty theft offender was just involved in a domestic violence incident, but the 273.5 charges would not be upheld for conviction. This is a subjective analysis by both the police and BRC. The subjectivity should be removed from the selection criteria process, and the offenders should be sentenced on specific domestic violence charges. According to the BRC Intake Officer, the majority of participants are sentenced on 273.5 offenses. The Director of the Correctional Services Division estimates that 97% of the BRC Domestic Violence Program participants are 273.5 offenders. However, on a given February 2002 day, 10% of BRC program participants were 666 offenders.

The audit team was provided with a list of the Selection Criteria that was pulled together for the audit; and therefore did not exist prior to the audit. This bulleted list of selection criteria needs to be transformed into formal criteria and policies of selection. According to the list, in order for an inmate to be considered for the Domestic Violence Program, he must meet the following criteria:

- Must be medically and psychologically cleared by Medical Services and DMH to be housed at BRC;
- Cannot be on parole; however probation is permitted;
- Cannot have any convictions for escape (walk-away violations are evaluated individually);
- Cannot have any "Strikes" against him;
    - However, during interviews it was noted that BRC would accept one-strike offenders.
- Cannot display or demonstrate unusual behavioral problems;
- Cannot be a gang member requiring administrative housing;
- Must have a lower security classification;
- Must be willing to accept some inmate rights restrictions (e.g., telephone/visiting); and,
- Cannot have any prior charges of assault on police officers.

In addition to this list, it was reported during interviews that homosexuals are not accepted into the Bridges to Recovery Program. However, homosexuals are allowed into the IMPACT Program. Both programs are housed at BRC.

BRC is primarily a "well facility" and has a limited medical staff. Any inmate being considered for the Domestic Violence Program at BRC must be free from a variety of medical problems, such as asthma, diabetes, special diets, orthopedic problems, and mental illness. In addition to certain medical disabilities, inmates must be able to walk unassisted up and down the relatively steep incline within the facility.

HLPSD staff has not been a part of developing any of the selection criteria. As the designated treatment agency for the Bridges to Recovery Program, HLPSD should be a part of developing the selection criteria as well as being involved in the screening and enrollment process. The BRC Bridges to Recovery Program was developed by bringing together the knowledge and expertise of both the correctional safety component (the Sheriff's Department) and the treatment component (Hacienda La Puente School District). Incorporating the knowledge and expertise of the HLPSD treatment staff is crucial to ensuring that the inmates who would benefit the most from participation are given the highest enrollment priority. In order to help ensure the success of the BRC Bridges Program, all aspects of the program development, including the screening and enrollment process, must be run cooperatively between both the treatment coordinators, HLPSD and the correctional security officers, the Sheriff's Department.

SELECTION PROCESS

The actual process of selecting the potential BRC Bridges program participants includes:

- Determining the pool of potential participants,
- Determining which of the eligible inmates accept enrollment; and,
- Determining which of the eligible inmates decline enrollment.

Each of these selection criteria components need to be structured, formal and well-documented, to determine the overall need, the potential pool of candidates for the Bridges Program and what percentage of that need is being met by the 60-bed facility. We were unable to develop any conclusions regarding domestic violence treatment needs for the LA County inmate population, due to the lack of documentation and structure around the selection process.

The selection process begins when the Inmate Reception Center (IRC) generates a list of names, organized by facility, and based on the list of offenses and the amount of time remaining on the inmate's sentence. After receiving this list, the BRC Officer searches for inmates with anywhere from 6 weeks to 3 months left on their sentences have no security problems where they are housed, no history of assault on police officers or counselors, and no murder convictions. The goal is to have the appropriate inmate go through the BRC Domestic Violence program immediately prior to release from custody. If the inmate completes the BRC Domestic Violence course prior to his release from custody, the remaining time will continue to be served at the BRC facility, where the inmate will take the same classes and additional academic courses, and become trustees on work detail.

The vast sentencing window of 6 weeks to 3 months should be limited to be as close to 6 weeks as possible, given the fact that the course is 6 weeks long. This would allow for additional inmates to participate in the program, rather than fewer inmates participating in the program for longer than the curriculum requires. The need for work trustees to run the facility should be analyzed to determine if the current program inmates could run the facility rather than accepting inmates with 3 months left in order make them trustees after they have graduated. This appears to be an inefficient use of program bed space.

If the inmate is not appropriate for the BRC Domestic Violence Program, the BRC Officer will send an informal email or phone message to the Classification Team at the Inmate Reception

Center to notify them of the disqualification. The only other documentation of disqualification occurs by the BRC Officer "putting a line through the inmate's name" on his list of potential program participants. Once the list is reviewed and inmates are chosen, the lists are thrown away. The same previously disqualified inmates may continue to appear on future lists because they meet the same criteria. The process of remembering who is disqualified lies in the memory of one officer at BRC. This disqualification process should be documented and formalized so that other BRC officers are capable of conduction the selection process.

The selection process is not systematic or well documented. There is no documentation or process for determining:

- Whether all potential BRC candidates are screened,
- How many of those potential candidates are qualified for the program, and
- How many are actually admitted against this potential pool.

The Sheriff's Department needs to develop adequate tools to systematically assess and record admission decisions, so that the BRC Bridges program can be adapted to the domestic violence needs of the correctional population. In addition, the HLPSD staff needs to be formally involved in the selection process to help determine the pool of potential participants and the disqualification.

ORIENTATION AND REGULATIONS

All inmates that are selected for the BRC Domestic Violence Program will go through an orientation process. According to a bulleted document list, the following items are checked off during the orientation:

- Correspondence, Visiting, Television, and Telephone usage rules
- Personal Care and Hygiene/Showers/Clothing & Bedding Exchange
- Rules and Disciplinary procedures
- Inmate Grievance procedures
- Programs and activities available, and method of application
- Medical Services (Nurse) over the counter medication
- Classification/Housing assignments
- Court Appearances
- Stores/Vending/Magazines
- Outdoor recreation and exercise
- Religious services
- Inmate information request forms
- Meals
- Library
- Inmate Voting

There is a lack of formality to this orientation process. The orientation can take from 10 minutes to 1 hour, depending on who is conducting the orientation (as observed during an on-site visit). While the one intake officer conducts most orientations, if he is not available or on-site, other

officers may be required to conduct the orientation; and yet the intake officer has not formally trained them to perform these duties. There is a need to train a number of officers to provide consistent inmate orientation at the facility, with the same information provided to each program participant.

In addition to the BRC orientation conducted by the Sheriff's staff, there is also a Bridges to Recovery orientation provided by the HLPSD staff. This is also an informal orientation, where a staff member will talk with the inmate, have the inmate sign a confidentiality form and review the inmate's class attendance sheet. A formalized checklist of specific program criteria and expectations needs to be developed. A formalized orientation process should be developed by HLPSD and integrated with the Sheriff's orientation process. Hacienda staff should be trained in this new process so that each inmate receives a consistent orientation.

After arrival at BRC, continued participation in a program is completely voluntary on the part of the inmate. Those electing not to participate are returned to general jail population. Any inmate, who continually demonstrates through his actions or conduct that he has become disruptive to the program, will also be returned to general jail population.

The rules and regulations at BRC appear to be implemented consistently and the results appear to be effective. Attachment 4 has the list of Inmate Rules and the list of Expectations & Agreement. Since the program inception in July 1999, there has been no reported inmate on inmate or inmate on staff assaults. There has also been no use of force by the correctional officers. This impressive safety record also demonstrates that the correctional staffing patterns at BRC appear to be appropriate and effective for the targeted inmate population.

IMPROVEMENTS TO PROGRAM PROCESSES AND OPERATIONS

The following seven common mainstream procedures for batterers intervention programs were identified by the National Institute of Justice:

- ***Intake***: First contact with batterer referred by the criminal justice system.

- ***Assessment***: Client agrees with terms of the program and is assessed for dangerousness, extent of abuse, substance abuse, mental illness, illiteracy, or other obstacles to treatment. Intake assessment may last up to 8 weeks and is designed to convince the clients to agree to the terms of the intervention, begin the behavior assessment, and screen for other problems. Ideally, the initial session begins to foster rapport between the clinician and the batterer.

- The BRC Domestic Violence Program is missing some key components of assessment. The Screening and Intake process from the correctional standpoint appears to identify those inmates who may pose a safety threat or be medically unfit to be at BRC. HLPSD administers a literacy test (WRAT) and a basic education level test (TABE) to determine if there are illiteracy issues. It was reported by HLPSD, however, that they consistently accept Sheriff approved inmates. Therefore, the education and literacy assessments should be completed earlier in the intake process so that HLPSD has the opportunity to reject inmates based on the assessment criteria. The HLPSD assessment component should be expanded to assess other obstacles to treatment, such as the extent of the inmates' abusive behavior, other behavioral issues, etc. The assessment component needs to be formalized, program driven and documented.

- ***Victim Contact***: Partners may be notified about the batterer's status in the program and of any imminent danger and referred to victim services

  - Los Angeles County has a notification program called VINE that is run out of the Inmate Reception Center. The VINE program was not evaluated for effectiveness by this audit team. The audit team did not discover any formal Bridges program links to the VINE program.

- ***Orientation***: An initial phase of group intervention that may be more didactic than later meetings. In this phase, program goals and rules for participating in the group are spelled out, and batterers are taught the program's underlying assumptions.

  - The orientation process at BRC is divided between the corrections end and the program end. Both processes are informal and vary depending on who is providing the orientation. This process needs to be formalized and the Sheriff's correctional orientation should be inter-linked with the Hacienda domestic violence program orientation.

- ***Group Treatment***: May involve a set of educational curriculum or less structure discussions about relationships, anger-management skills, or group psychotherapy.

  - The majority of the BRC Domestic Violence curriculum is presented through group treatment.

- ***Leaving the Program***: Batterers may complete the program, be terminated for noncompliance, or be asked to restart the program.

  - There is a zero tolerance policy at the BRC. If the inmate does not comply with any of the rules or regulations, he is dropped from the program and returned to general population. The inmate may also request to leave the program and will be returned to the main jail facility. The zero tolerance policy appears to be effective in terms of inmate and staff safety.

- Other than attendance at each of the 180 hours of class, the BRC Domestic Violence Program has no overall measurable program objectives, or clear criteria for successful program completion. There are defined class objectives, however, it is unclear how the defined class objectives are measured and documented for the staff and inmates know when those objectives are met.

- ***Follow-up***: May consist of informal self-help groups of program graduates or less frequent group meetings.

  - This is the largest gap in the services offered at BRC. There is no coordination with probation, no BRC staff understanding of court orders upon the inmate's release, and no connection with the Community Transition Unit. The inmates were recently provided with a one-on-one meeting with a part-time counselor to discuss what they will do upon release. There is no formalized process or required follow-up. However, the program offers weekly alumni meetings for graduates at the BRC site.

In addition to each of the process improvements noted above, the BRC Domestic Violence program must establish consistent documentation methodologies, not only in their disparate databases, but also in their case files. There is currently no standard for the case files for what information needs to be kept for each student. The criteria for graduation should be in each file and how each criterion was or was not met by each student. Progress reports, attendance records, discipline reports, intake and assessment forms, homework assignments, test scores, or other criteria need to be developed for graduation.

CONCLUSIONS

BRC Bridges to Recovery Program is a fairly new program, opened three years in July 2002. There have been a number of important changes and improvements in the program curriculum and operations throughout the program development. The conclusions below will continue to advance the Bridges Program towards formalizing the policies and procedures and documenting the program operations in order to determine successes and failures and continue to improve program operations.

Although there is a general BRC Domestic Violence Program goal, reasonable and measurable, overall program objectives need to be developed; as well as specific guidelines or procedures for determining (a) how that overall goal will be achieved, and (b) how inmates and program staff know when the goal has been met. Objective criteria for successfully completing the program need to be developed and communicated to inmates and staff. Program outcomes need to be validated with pre- and post-testing of the participating inmates.

A formal, state-approved course curriculum has been developed for Bridges program for each of the seven class groupings. The course description, class outlines, formal descriptions of goals and objectives and lesson plans are well documented; however, many of the course objectives are too broad and not measurable. Also, there is a need for a formalized process and documentation for determining if a student has successfully met all program objectives, and it is unclear how instructors know if students have successfully met class objectives.

There is no documentation or process for determining whether all potential BRC candidates are screened, or how many potential candidates qualify for the program. The Sheriff's Department needs to develop tools to systematically assess and record admission decisions so that the domestic violence program can be adapted to inmate treatment needs.

Formal criterion and processes for selection need to be developed. The bulleted list of selection criteria created for the audit, needs to include all criteria, including the offenses accepted. Program participation should be limited to individuals convicted of domestic violence related charges only, so that selection subjectivity by the intake officer is controlled. The selection criteria based on the time remaining on the inmate sentence needs to be formalized and more consistently applied. A formal and thorough assessment process needs to be developed by the HLPSD program staff in order to determine the appropriateness of each program participant and obstacles that may prevent effective treatment.

The vast sentencing window of 6 weeks to 3 months should be limited to be as close to 6 weeks as possible, given the fact that the course is 6 weeks long. This would allow for additional inmates to participate in the program, rather than fewer inmates participating in the program for longer than the curriculum requires. The need for work trustees to run the facility should be analyzed to determine if the current program inmates could run the facility rather than accepting inmates with 3 months left in order make them trustees after they have graduated. This appears to be an inefficient use of program bed space.

The BRC facility orientation process, conducted by the Sheriff's Department is unstructured and not formalized, and the thoroughness of the orientation appears to be based on the preferences of the individuals conducting the orientation, guided by a brief checklist of items to cover. Formalized materials need to be developed so that each inmate receives the same level of orientation. The Bridges to Recovery program expectations and criteria should be incorporated into the Sheriff's orientation process, creating a single, co-lead orientation between the Sheriff and HLPSD. A more in-depth assessment process can be conducted solely by HLPSD for determining program placement, limitations to program success, etc. Also, formal training for anyone who may conduct the orientation needs to be developed and implemented consistently for both the Sheriff's staff and HLPSD.

A more extensive and formal process for transitioning inmates into the community needs to be developed and supported by more than one part-time counselor. A curriculum should be developed and formally implemented, and contact with the LASD Community Transition Unit and Probation Department are essential if inmates are to successfully transition to the community.

RECOMMENDATIONS

The Sheriff should direct the Correctional Services Division managers to:

1.1 Develop guidelines and procedures for determining (a) how the Bridges to Recovery Center Program goals will be achieved, and (b) how inmates and program staff will identify when those goals have been achieved. (Recommendation 72)

1.2 Develop measurable and reasonable objective criteria for determining program success, and a process to ensure that such criteria are communicated to inmates and staff. (Recommendation 73)

1.3 Develop and implement policies and procedures necessary for maintaining inmates for as close to the 6-week program curriculum as possible. (Recommendation 74)

1.4 Document a formalized process for screening inmates for program admission that includes all criteria to be used by screening personnel. (Recommendation 75)

1.5 Train additional personnel on eligibility and admission screening procedures. (Recommendation 76)

1.6 Establish a formalized process for documenting eligibility screening results, so that the pool of potential program candidates, and selected and rejected candidates can be identified by reason. (Recommendation 77)

1.7 Limit Bridges to Recovery program participation to inmates with a clear domestic violence criminal history. (Recommendation 78)

1.8 Establish procedures to ensure that adopted screening criteria are consistently applied. (Recommendation 79)

1.9 Work with Hacienda La Puente School District managers to incorporate program assessment criteria into the LASD screening process. (Recommendation 80)

1.10 Establish a formalized inmate orientation process, which includes standard materials and relies upon staff who have been fully trained in aspects of the program. (Recommendation 81)

1.11 With the HLPSD, develop a more extensive and formal process for transitioning inmates into the community, which includes involvement of the LASD Community Transition Unit and the Los Angeles County Probation Department. (Recommendation 82)

The Hacienda La Puente School District Superintendent should direct Correctional Education Division managers to:

1.12 Consider increasing counselor hours to assist inmates with community transition. (Recommendation 83)

1.13 Establish mechanisms to ensure that the Bridges to Recovery Program classes mirror formalized course descriptions, course goals and objectives. (Recommendation 84)

1.14 Establish systems and procedures to ensure that course instructors are able to determine whether students have successfully met class objectives. (Recommendation 85)

1.15 Develop measurable and reasonable course objectives and methods for measuring objectives, including pre and post testing for all course groupings. (Recommendation 86)

COSTS AND BENEFITS

Increasing HLPSD counselor hours to assist inmates with community transition would cost approximately $40,685, if current service levels were doubled. Although the Sheriff's Department may have some increased costs to provide training to staff, we believe such costs would be minimal.

Program goals and objectives would be more clearly defined, and implementation processes would be more standardized. Program screening data would be enriched and more accurate. Course content would be more closely aligned with program intent. The Sheriff's Department would be better able to assess Bridges to Recovery Program effectiveness.

2. PROFILE OF PROGRAM PARTICIPANTS

- **A validated and complete unduplicated count of Bridges to Recovery program participants was not obtained due to the disparate data systems that track participants and the delayed responses to our participant profile data requests. Three samples were conducted to obtain snapshot profiles of the participant population, which found that demographic trends are generally consistent. The typical participant is Hispanic male, aged 35, with multiple offenses, prior arrests and convictions.**

- **The statistical profile should be expanded to include all participants in the program, and the survey methodology should be improved to increase data reliability. Some elements of the survey could be captured more reliably from other sources. Further, a single source of information should be developed to track program participants. The BRC Student Records Database could be expanded to include additional profile data such as the information included in the BRC survey and Correctional Services Division recidivism study. The reasons for data omissions and errors need to be identified and analyzed to limit record inconsistencies.**

- **Of the 229 graduates analyzed for the Correctional Services Division March 2002 recidivism study, there were six graduates who attended the program based on "miscellaneous charges". A comprehensive review of all charges should be conducted so that the program remains focussed on serving the targeted population.**

- **Based on a sample of BRC Student Records, we found that the average length of stay is quite long for the inmates who were released prior to graduating (78.2 days), or graduated but were released from custody after the graduation date (90.5 days). This demonstrates a need to track "drop" reasons, to develop a process for dealing with inmates who are not progressing through the program, and to define program goals and objectives for dealing with inmates who remain at the facility after successfully completing the program while awaiting release. Because the program is based on a six-week curriculum (42 days), the average length of stay for graduates was twice as long as the length of the curriculum. To the extent program participants spend more time than required at the facility, other potential participants cannot be served. A review of the inmate selection process should be conducted to ensure that only those inmates are selected who have as close to six weeks remaining on their sentence as possible.**

There are nationally validated data that profile domestic violence offenders. The majority of arrested batterers are heterosexual men. According to the 1992 National Crime Victimization Survey, 51 percent of domestic violence victims were attacked by a boyfriend or girlfriend, 34 percent by a spouse, and 15 percent by a former spouse. The backgrounds of incarcerated batterers are similar to those of offenders convicted of assaults against strangers and acquaintances: half grew up living with both parents; 12 percent had lived in a foster home; 22 percent had been physically or sexually abused; 31 percent were the children of substance abusers; and, 35 percent had a family member who had been incarcerated. Less is known about the demographic characteristics of low-risk or "typical" batterers, but program staff and probation officers emphasize the cultural and economic diversity of these offenders.

There are no validated data profiling the BRC Bridges domestic violence offenders. A complete profile of BRC Domestic Violence program participants could not be attained from the limited information provided by the BRC program. Numerous delays in our participant profile data requests led to hard copies of record sheets being sent to us quite late in the audit process. Based on the timing, we were only able to develop a sample of profile data. It is estimated that a total of 804 inmates have participated in the Biscailuz Recovery Center Domestic Violence Program since program inception in July 1999. A validated unduplicated count of program participants could not be attained due to the multiple, disparate computer systems used at BRC, including:

- The BRC Student Records Database: The HLPSD created this database to track students at the BRC when they enter and leave the program, and to document the certificates that the inmates receive.

- The Certificates Database: The HLPSD created this database to track all certificates issued by the Hacienda La Puente Correctional Education Division.

- The Paradox Database: This database was developed for BRC purposes only and used by the Sheriff's Department to track program inmates.

- The Quattro Pro spreadsheet: This tracking system was developed based on files and paperwork. Program participants' data was entered into this spreadsheet, to track all inmates sent to BRC. The accuracy of data in this system could not be validated.

None of these four systems are cross-referenced. Therefore the data that resides within each system vary. Further, due to these disparate data systems and the ongoing delays and client confidentiality obstacles that arose in response to our data requests, a complete and validated program profile of all participants could not be completed. Our original project goal was to determine a profile of all BRC Bridges program participants by:

- General Offense Category
    - Misdemeanor Domestic Violence
    - Felony Domestic Violence
    - Assault
- Sentence Type (current conviction only)
    - County jail time only (in-custody time)
    - County jail time with formal probation (in-custody & probation time)
    - County jail time with informal court probation (in-custody and probation time)
- Prior Record
    - Total prior arrests and convictions
    - History of domestic violence (arrest and conviction)
    - History of assault (arrest and conviction)
- Collateral Services Received
    - Probation supervision
    - Drug and alcohol counseling
    - 52-week domestic violence counseling after release from custody

Because we were never able to receive a valid, unduplicated count of program participants with client identifying information, we were unable accomplish our proposed project goals. Although we received a series of hard-copy BRC Student Records in late April 2002, these did not contain consistent client identifying information and were received too late to proceed with creating a new database, identifying data errors and duplicates and then requesting additional data based on our initial analysis of the data set.

However, the BRC Domestic Violence Program independently developed the following three distinct and limited program participant profiles:

- The BRC Student Database Profile
- The Bridges to Recovery Student Profile Survey
- The BRC Domestic Violence Graduate Profile

BRC STUDENT DATABASE PROFILE

We could not complete a review of the BRC Student Records database during the timeframe that existed after receiving records from the HLPSD. After numerous delays fulfilling our request for the BRC Student Database, including questionable claims of client confidentiality, we received hard copies of each of the student's records. HLPSD chose to withhold electronic records because of management concerns regarding data reliability. However, based on the information that was received, we were able to analyze a sample of the records provided.

The BRC Student Records Database was developed and is maintained by the HLPSD staff that are involved in the Bridges to Recovery program. According to the HLPSD, the records received represent a comprehensive list of all inmates who have participated in the BRC Bridges to Recovery program since program inception in July 1999. However, our review of the records discovered that they capture a limited amount of data, primarily demographic and program start and end dates. Also, there is a lack of data consistency: there is no consistent pattern of entered dates (e.g., a graduation date may be filled in but the release date is missing).

Of the 763 records received, a sample of 100 records demonstrated the following:

- The average age of program participants is 34 years old
- The ethnicity of the participants are:
    - 62% Hispanic
    - 18% White
    - 16% Black
    - 3% Asian
    - 1% Native American
- The overall average length of stay at the BRC Bridges program is 64 days.
    - 41.4 days is the average length of stay for program graduates.
        - This is consistent with the program curriculum, which is 6 weeks in duration (42 days).
    - 44.8 days is the average length of stay for the inmates who were dropped from the program for non-compliance.
        - This is quite a long time for the inmate to remain at BRC and participate in the program, and then to decide to not comply with program rules. For future analysis, BRC should track the reasons for these "drops."
    - 78.2 days is the average length of stay for inmates who were released prior to graduating.

- This is an exceptionally long duration for inmates to participate in a 6-week program and be released from custody prior to graduating. This demonstrates a need to develop and implement a process for dealing with inmates who are not progressing through the program. Instead of removing the inmate, he remains at the facility for almost twice as long as the program duration and still does not graduate.

➢ 90.5 days is the average length of stay for inmates who graduated, but were released from custody after the graduation date

- This is another instance where inmates are kept on site at BRC long after program completion. The goals of the program need to be defined to determine if a goal is for inmates to remain on-site after successfully completing the program while awaiting his release.

- On average, those inmates who remained at BRC after they graduated from the program remained at the facility for an extra 38.9 days.

BRC RELEASE GROUP SURVEY PROFILE

Another program participant profile was developed by the HLPSD from a survey that was completed by the students participating in the Release Group that meet on Monday afternoons, one to two weeks prior to their release. These statistics are representative of students that have enrolled in the program (not just graduates) and do not represent students that have been removed from the program prior to release.

The surveys were collected from 145 students between March 2001 through January 2002. As with most surveys, there are significant data reliability issues, due to the respondents' understanding and the veracity of their answers. Also, the survey was yes/no driven; there are no choices for unknown. For instance, some offenders may not know if they were arrested on a new charge or violation of probation, or if they will be placed on probation after release.

Accounting for the limitations of this survey, the profile of the 145 students respondents shows that the typical program participant:

- Is a single Hispanic male between the ages of 21 to 25, or 36 to 40 years old,
- Is a father with an average of two children,
- Is a high school graduate,
- Is not a veteran,
- Has previously served time in jail,
- Was employed at the time of arrest, but does not have a job upon release,
- Was under the influence when arrested,
- Was arrested on a new charge or probation violation equally,
- Will be on probation when released, but may or may not be required to attend domestic violence classes after release, and
- Will stay with family members when released.

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TABLE 1:
BRC RELEASE GROUP SURVEY RESULTS

	SURVEY RESULTS	
Age at the time of arrest 18-20: 7% 21-25: 20% 26-30: 15% 31-35: 15% 36-40: 20% 41-45: 14% 46+ : 9%	**Veterans** Yes: 6% No: 94%	**Under the influence when arrested** Yes: 51% No: 49%
Ethnicity Hispanic: 69% White: 14% Black: 14% Other: 3%	**Served Prior Time in Jail/Prison** Yes: 62% No: 38%	**Probation upon release** Yes: 69% No: 31%
Marital Status Married 33% Single 38% Divorced 6% Living Together 9% Separated 6% Engaged 7% Widowed 1%	**Arrested as:** Charge: 50% Violation: 50%	**Required to do classes upon release** Yes: 50% No: 50%
Number of Children 0: 19% 1: 21% 2: 23% 3: 17% 4: 14% 5+: 6%	**Employed at the time of arrest:** Yes: 66% No: 34%	**Upon release, will stay with:** Family: 45% Spouse: 27% Significant Other: 7% Alone: 19% Rehabilitation: 2%
Education Level Diploma: 57% GED: 6% Non-grad: 37%	**Employed upon release:** Yes: 33% No: 67%	

PROFILE OF BRC DOMESTIC VIOLENCE PROGRAM GRADUATES

The Sheriff's Department Correctional Services Division completed a BRC Domestic Violence Program Recidivism study in March 2002. This study captured participant profile and outcome information on the graduates of the BRC Bridges to Recovery Domestic Violence Program from June 1999 through July 2001. Although there were a total of 419 graduates during that timeframe, only 229 subjects were included in the study because 22 cases were duplicates, 72 cases were missing, 7 cases were for individuals in non-graduate status, 1 case contained inconsistent demographic data, and 88 cases fell outside of the study timeframe (i.e., graduating before or after the study timeframe). A total of 102 cases were excluded from the study due to data inconsistencies and database issues. In particular, the 72 missing cases, where the inmate is shown attending BRC, but their attendance and graduation could not be validated, needs to be reviewed and analyzed so that further missing cases are not generated.

Of the final sample of 229 graduates, their demographic profile was:

- Ages 19 to 58, with the average age of 36 years old;
- Age at first arrest ranged between 11 and 51 years of age, with the average age of 25
- 57% Hispanic
- 21% African American
- 19% Caucasian
- 1% Asian
- 2% Other

The number of prior arrests that occurred prior to the Bridges to Recovery program of the graduates ranged from 0 to 45 with an average of 6 prior arrests. Prior convictions ranged from 0 to 18 with an average of 2.6 prior convictions.

The arrest data for the 229 graduates included:

- 72% were arrested for domestic violence (273.5 PC),
- 13.5% were arrested for battery on person (243 PC),
- 5.2% were arrested for battery on person (242 PC),
- 4.4% were arrested for violating domestic court order,
- 2.4% were arrested for miscellaneous charges, and
- 1.7% were arrested for assault with a deadly weapon (245 PC).

This statistical profile is consistent with the selection criteria used by the BRC Intake Officer when choosing program participants. The finding of six graduates who attended the program based on "miscellaneous charges" is unusual since the program is subject specific for domestic violence. A review of all charges should be completed in order to ensure that the program is serving the appropriate domestic violence offenders.

The length of sentence for program graduates ranged from 27 to 378 days with an average stay of 219 days at some LA County Correctional facilities. The average length of custody stay for these graduates is five-times the length of the 6-week program curriculum; however, there was no available data to determine how long these program graduates stayed at BRC during their average 219 custody stay.

CONCLUSIONS

A validated and complete unduplicated count of Bridges to Recovery program participants was not obtained due to the disparate data systems that track participants and the delayed responses to our participant profile data requests. Three samples were conducted to obtain snapshot profiles of the participant population, which found that demographic trends are generally consistent. The typical participant is Hispanic male, aged 35, with multiple offenses, prior arrests and convictions.

The survey profile should be expanded to include all participants in the program, and the survey methodology should be improved to increase data reliability. Some elements of the survey could be captured more reliably from other sources. Further, a single source of information should be developed to track program participants. The BRC Student Records Database could be expanded to include additional profile data such as the information included in the BRC survey and Correctional Services Division recidivism study. The reasons for data omissions and errors need to be identified and analyzed to limit record inconsistencies.

Of the 229 graduates analyzed for the Correctional Services Division March 2002 recidivism study, there were six graduates who attended the program based on "miscellaneous charges". A comprehensive review of all charges should be conducted so that the program remains focussed on serving the targeted population.

Based on a sample of BRC Student Records, we found that the average length of stay is quite long for the inmates who were released prior to graduating (78.2 days), or graduated but were released from custody after the graduation date (90.5 days). This demonstrates a need to track "drop" reasons, to develop a process for dealing with inmates who are not progressing through the program, and to define program goals and objectives for dealing with inmates who remain at the facility after successfully completing the program while awaiting his release. Because the program is based on a six-week curriculum (42 days), the average length of stay for graduates was twice as long as the length of the curriculum. To the extent program participants spend more time than required at the facility, other potential participants cannot be served. A review of the inmate selection process should be conducted to ensure that only those inmates are selected who have as close to six weeks remaining on their sentence as possible. The program objective of releasing each graduate directly from BRC and not having them return to general population can still be met if more care is taken at the front end when choosing the inmates for participation based on their length of time remaining in custody.

RECOMMENDATIONS

The Sheriff should direct the Correctional Services Division managers to:

2.1 Expand future statistical analyses and surveys to include all participants in the program, and to include more data elements (as described in the body of this report). (Recommendation 87)

2.2 With HLPSD, develop a single database of information for tracking inmate participation in the Bridges to Recovery Program. (Recommendation 88)

2.3 Ensure that criminal charge data is accurately recorded so that it can be ascertained that the program focus remains on domestic violence. (Recommendation 89)

2.4 Review the inmate selection process, and establish procedures that will ensure that only those inmates with six weeks left on their sentences (approximate) are enrolled in the program. (Recommendation 90)

2.5 Ensure that reasons for dropping an inmate from the program are consistently and reliably tracked. (Recommendation 91)

2.6 Develop a formalized process for dealing with inmates who are not progressing through the program in an expected timeframe. (Recommendation 92)

The Superintendent of the Hacienda La Puente School District should direct Correctional Education Division managers to:

2.7 Work with the Sheriff's Department to establish a single database of information for tracking inmate participation in the Bridges to Recovery Program. (Recommendation 93)

2.8 Work with the Sheriff's Department to establish protocols for dealing with inmates who are not meeting program criteria and objectives in a timely manner. (Recommendation 94)

COSTS AND BENEFITS

There would be no costs to implement these recommendations.

A validated and complete unduplicated count of program participants would be developed. Statistical analysis and the evaluation of program results would improve. The capacity of the program would be increased as inmate stay more closely approximates the curriculum duration. The Sheriff's Department would be better able to assess Bridges to Recovery Program effectiveness.

3. PROGRAM COSTS

- **Analysis conducted for this study indicates that the average cost per inmate day is approximately $105, which is higher than in many of the County's other jail facilities. Although recent analysis of the average cost in other facilities was not provided by the Sheriff's Department, discussions with administrative managers indicate that it is as low as $50.**

- **The total Sheriff's Department and Hacienda La Puente School District cost for operating the Biscailuz Recovery Center equals approximately $4.7 million per year for both the Bridges to Recovery and IMPACT programs. Because there is sufficient capacity to house the average daily population of 101 inmates in the County's other jails, the costs to operate the Biscailuz Recovery Center represent a variable cost which could be nearly eliminated if the facility was closed.**

- **The average cost per inmate participant equals approximately $7,656 since program inception. The average cost per graduate equals approximately $12,985 during the same period. Because these high average costs are nearly all variable, it is incumbent upon the Sheriff to monitor costs closely and incorporate averages as measures of performance in any cost-benefit analysis it conducts of the Biscailuz Recovery Center Bridges to Recovery Program.**

The Biscailuz Recovery Center is one of ten jail facilities operated by the Los Angeles County Sheriff's Department, excluding the Inmate Reception Center which is used by the Sheriff to process inmates into the custody system. On any given day, the Sheriff houses approximately 19,000 to 20,000 prisoners in the County's jails. In FY 2000-01, the Sheriff housed an average of 19,315 prisoners each day, 101 of whom were housed at the Biscailuz Recovery Center (0.5%).

Each of the Sheriff's jail facilities costs a different amount to operate. This variability in costs is determined by a number of factors, including:

- The design and configuration of the facility;
- The security classifications of the prisoners housed at the facility;
- The function of the facility (e.g., pre-sentenced vs. sentenced);
- The support functions required at the facility (e.g., medical); and,
- The programming provided at the facility.

The Biscailuz Recovery Center is one of the smallest jails in the County system. It is an older facility, designed for minimum security inmates who are housed in dormitory style barracks. Food service is provided centrally from a dining hall, and minimum medical services are provided on-site. The Sheriff has renovated several of the barracks to provide classroom space for inmate programming.

Many of these characteristics provide operational efficiencies, and the design and atmosphere at the facility is clearly conducive to the learning and recovery environment. However, because of the small size of the facility, the ratio of custody staff required to manage the inmate population is higher than in other County jail facilities. This directly impacts the average cost of custody services provided to inmates at the BRC, making them higher than in some of the other larger and newer jail facilities in the County.

However, the relative cost comparison between the BRC and other County jail facilities is irrelevant for purposes of this analysis. Because the average inmate population at the BRC averages approximately 0.5% of the total population in the County's jail system, the BRC inmate population could be entirely absorbed within the other jails without any commensurate increase in staffing or costs at the other facilities. In FY 2000-01, the total population in the County's jail system averaged between 18,916 inmates in January 2001, to 20,121 inmates in October 2000. We believe the entire BRC population of 98 (January) and 107 (October) inmates could have been absorbed within the other County jail facilities without hardly any operational impact.

Therefore, for purposes of this analysis, we consider the entire custody cost of operating the BRC facility to be variable – that is, if the facility were closed, the County could save nearly $4.4 million in custody operating costs by reducing the requirement for management and direct service personnel.[2] There would be no additional custody cost related to moving the prisoners to other County jail facilities.

As with the Sheriff's Department cost of custody services, the educational and counseling services of the Hacienda La Puente School District are variable. If the domestic violence treatment program were discontinued, approximately $370,000 in HLPSD costs could be saved annually.[3]

We are not recommending that the BRC facility be closed at this time. However, because the total program costs Los Angeles County taxpayers approximately $4.7 million each year, and because these costs are nearly all variable, it is important for that costs be closely tracked, measured and incorporated into future program cost-benefit analyses. At the time of this report, no analysis of costs had been conducted by the Department or shared with our staff, and certainly no integrated cost-benefit analysis had been performed.

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[2] The Sheriff's FY 2001-02 budgeted cost for operating BRC is approximately $4.4 million. Of this amount, approximately $40,000 represents the incremental direct costs associated with housing prisoners, including food service, laundry, and other similar services.

[3] It is important to note that 100% of the services provided by the HLPSD are funded by the State through the California Jail Education Apportionment Fund, based on average daily attendance of the students (ADA); and, by the Inmate Welfare Fund, which are trust fund monies managed by the County which must be used to support inmate services. In FY 2001-02, the HLPSD estimates that approximately 70% of BRC funding came from the State, with the balance of 30% coming from the Inmate Welfare Fund.

AVERAGE PROGRAM COSTS

There are three basic, but key cost measurements which should be tracked by the Sheriff's Department as it proceeds to refine the program evaluation model it is developing for the Bridges to Recovery Program. These include:

- The average cost per inmate day;
- The average cost per inmate participant; and,
- The average cost per inmate graduate.

The cost for each of these components should be segregated by custody cost and treatment cost. They should also be measured since program inception, and on an annual basis, to provide a baseline against which program cost effectiveness can be measured. The table below provides the averages for each of these suggested measurements for the period July 1999 through February 2002.

TABLE 2:
AVERAGE CUSTODY AND TREATMENT COSTS

July 1999 through February 2002	Sheriff's Department	Hacienda La Puente	Total
Gross Program Cost (A)	5,400,519	754,552	6,155,071
Total Inmate Days	58,400	58,400	N/A
Number of Bridges Inmates	804	804	804
Number of Bridges Graduates	474	474	474
Cost Per Inmate Day	92	13	105
Cost Per Bridges Inmate	6,717	938	7,656
Cost Per Bridges Graduate	11,393	1,592	12,985
Percent of FY 2001-02 Elapsed	67%		

(A) Represents 50% of BRC operating cost since one half of the facility houses IMPACT program inmates.

As shown, the average cost of operating the BRC program equals approximately $105 per inmate day ($92 for custody and $13 for programming). Although the Sheriff's Department was unable to provide computations of inmate cost per day for the other jail facilities, discussions with administrative management staff at the Department indicate that the costs are as low as $50 per day at these other locations.

More importantly, the average cost per inmate who enters the Bridges to Recovery Program equals $7,656, which is significant since a maximum of only 60% of participants actually graduate from the program. The average cost per graduate equals approximately $12,985.

The Sheriff's Department brought numerous studies to our attention which describe the financial and societal cost of crime in the United States, and the costs of alternative out-of-custody

programs in Los Angeles County. While interesting, this information is irrelevant unless the Department is successful at measuring the *cost effectiveness* of its current program. Unless the Department can show that the BRC program is making an impact in terms of reducing recidivism, reducing injuries and death suffered by the victims of domestic violence, and reducing the other residual costs of violent crime, no claim can be made that the BRC program reduces the financial and societal cost to the community. Until this impact can be demonstrated, the costs of the BRC program must be viewed as an additional cost to the community with no proven results.

As demonstrated above, BRC operating costs are significant. It is therefore incumbent on the Sheriff's Department to conduct a thorough evaluation of program outcomes against program costs, to measure the cost-effectiveness of the program. As will be discussed in Section 4 of this report, the Department has been unable to conclusively demonstrate the effectiveness of the domestic violence treatment program to date.

CONCLUSIONS

Analysis conducted for this study indicates that the average cost per inmate day is approximately $105, which is higher than in many of the County's other jail facilities. Although recent analysis of the average cost in other facilities was not provided by the Sheriff's Department, discussions with administrative managers indicate that it is as low as $50.

The total Sheriff's Department and Hacienda La Puente School District cost for operating the Biscailuz Recovery Center equals approximately $4.7 million per year for both the Bridges to Recovery and IMPACT programs. Because there is sufficient capacity to house the average daily population of 101 inmates in the County's other jails, the costs to operate the Biscailuz Recovery Center represent a variable cost which could be nearly eliminated if the facility was closed.

The average cost per inmate participant equals approximately $7,656 since program inception. The average cost per graduate equals approximately $12,985 during the same period. Because these high average costs are nearly all variable, it is incumbent upon the Sheriff to monitor costs closely and incorporate averages as measures of performance in any cost-benefit analysis it conducts of the Biscailuz Recovery Center Bridges to Recovery Program.

RECOMMENDATIONS

The Sheriff should direct the Correctional Services Division managers to:

3.1 Develop and implement an appropriate model for measuring the average cost per inmate day, the average cost per program participant and the average cost per program graduate for the Bridges to Recovery Program. (Recommendation 95)

3.2 Incorporate the results of the cost model into a comprehensive cost-effectiveness evaluation, as discussed in Section 4. (Recommendation 96)

COSTS AND BENEFITS

There would be no additional costs to implement these recommendations.

The Sheriff's Department would be better able to assess the effectiveness of the Bridges to Recovery Program against the costs to the taxpayers.

4. PROGRAM RESULTS

- **We were unable to conduct an original analysis of program effectiveness and outcome data due the disparate data source systems and the continuously delayed responses to our data requests. We were unable to get a validated list of program participants and program graduates to track for recidivism analyses. Therefore, the recidivism analysis for this audit is based solely on a secondary review of two studies completed by the Sheriff's Department Correctional Services Division.**

- **In order to measure program effectiveness and program success with any validity, quantifiable measures must be established based on program goals and objectives. In order for quantifiable measures to be developed, overall program goals and objectives must be determined and must be measurable. The Bridges to Recovery Program lacks measurable and reasonable objectives, methods for measurement, quantifiable performance and outcome indicators, and a consistent method of capturing performance data.**

- **Program effectiveness cannot be determined, even though an estimated 44% to 59% of program participants graduate. An extensive amount of additional data must be consistently captured for all participants in order to obtain a more comprehensive understanding of program results, such as why others did not graduate, release dates and release reasons.**

- **Based on a sample of 229 graduates, the Correctional Services Division Recidivism study of the BRC Bridges program found a 30 day recidivism re-arrest rate of 4.1% and a 1 year cumulative re-arrest rate of 32.71%. Again, these results are inconclusive since additional data, such as domestic violence re-arrests, must be captured and analyzed to confidently determine whether the program impacts the domestic violence behavior of participants.**

- **A notable pattern evident from analysis of the 229 graduate data is that graduates continue to be arrested and re-arrested at a fairly consistent rate for up to the year after graduation. This suggests that an aftercare program that is coordinated with the Probation Department may be appropriate.**

BARRIERS TO EFFECTIVE TREATMENT

The National Institute of Justice (NIJ) states that there are a number of significant barriers to effective batterer treatment programs, most notably, the overall lack of services to meet the needs of convicted domestic violence perpetrators in the United States. Other factors the NIJ has identified that affect batterer treatment success are:

- Offenders who are ordered or mandated by a court to attend a treatment program may not be participating on a willing basis and may be resistant to change.
    - BRC is a unique correctional setting program where the inmate has a choice between participating in the BRC program or being housed in the general population. While the inmate is free to choose whether he will participate, it is unclear if the decision to participate results from a desire to change previous behaviors, or a desire to take advantage of the BRC living quarters and facility amenities.
- Many batterers programs are short in duration (ten to twelve weeks), leading many domestic violence advocates to observe that if battering is a behavior learned over a lifetime, it may take more than a few weeks to "unlearn" that behavior.
    - The BRC Domestic Violence program is based on an even shorter curriculum of six-weeks with little to no follow-up with the inmates. While the program offers post-release weekly meetings at the BRC site, there is very low attendance. BRC staff do not coordinate services with the LASD Community Transition Unit or with the Probation Department. Therefore, the inmates have just six weeks (some longer) to "unlearn" a lifetime of behavior.
- If a batterer is also alcohol/drug dependent, but receives treatment only for the violent behavior, then the correlating factor of substance abuse is not addressed
    - The BRC Domestic Violence Program has recognized the link between substance abuse and domestic violence and includes substance abuse curriculum in its program.
- There have been limited sound evaluations of the long-term success of batterers treatment programs

BATTERER INTERVENTION EVALUATIONS

While numerous evaluations of batterer interventions have been conducted, domestic violence researchers concur that findings from the majority of these studies are inconclusive because of methodological problems, such as small samples, lack of random assignment or control groups, high attrition rates, short or unrepresentative program curriculums, short follow-up periods, or unreliable or inadequate sources of follow-up data (e.g., only arrest data, only self-reported data, or only data from the original victim).

Among evaluations considered methodologically sound, the majority have found modest but statistically significant reductions in recidivism among men participating in batterer interventions. A notable exception is a 1991 methodologically rigorous quasi-experimental evaluation of batterer interventions in Baltimore, conducted for the Urban Institute. The study raised particular concern in the field by its unexpected findings that participants in all of the three batterer interventions recidivated at a higher rate than those in the control group. (Harrell, A. *Evaluation of Court Ordered Treatment for Domestic Violence Offenders*).

Preliminary results from a four-site study sponsored by the Centers for Disease Control are inconclusive: at 12 months, re-offense rates for program graduates are similar to those for batterers who dropped out at intake, and no significant variations exist in outcomes for batterers in programs of varied length and curriculum (although a three-month, pretrial, educational program has shown slightly better outcomes when socioeconomic factors are taken into account). (Edward Gondolf, *Multi-Site Evaluation of Batterer Intervention Systems*).

A 1996 study by J.S. Goldkamp, *The Role of Drug and Alcohol Abuse in Domestic Violence and Its Treatment*, suggests that offenders with prior arrests involving the same victim, prior domestic violence or assault and battery arrests, and drug involvement may be at highest risk for re-offending. Batterers who were drunk once a month re-offended at three times the rate of others in the study.

Frustration with the lack of empirical evidence favoring one curriculum or length of treatment has led some researchers to increasingly look at batterers as a diverse group for whom specially tailored interventions may be the only effective approach. It seems likely that even if research identifies the perfect matches between offenders and interventions, criminal justice and community support for the interventions will have a crucial impact on the effort's success. Andrew Klein, chief probation officer of the Quincy, Massachusetts, District Court Model Domestic Abuse Program, observed, "You can't separate batterer treatment from its (criminal justice system) context. You can't study the effectiveness of treatment without studying the quality of force that supports it."

Unfortunately, this audit of the BRC Domestic Violence program was unable to study the "quality of force that supports the program" (the probation data supporting the BRC program). As noted above, the numerous data request delays did not allow time for a probation data request to be met. In addition, the data delays and obstacles prevented our full and original analysis of program effectiveness data such as:

- Program Completion Rates of total participants
- Recidivism arrests
  - For new misdemeanor and felony offenses generally
  - For new misdemeanor and felony domestic violence offenses
- Recidivism convictions
  - For new misdemeanor and felony offenses generally
  - For new misdemeanor and felony domestic violence offenses

- Linking the recidivism rates to probation data
  - Formal vs. informal probation
  - Those assigned to 52-week domestic violence aftercare program
- Comparison group analysis of the same recidivism data

Our program effectiveness analysis is limited to a secondary review of the two recidivism studies completed by the Sheriff's Department Correctional Services Division. Some additional program completion information was gathered from the Hacienda BRC Student Records Database and the Hacienda Certificates Database.

PROGRAM COMPLETION RATES

Another gap of available data for the BRC Bridges Program is the documentation of program completion rates. It is unclear exactly how many inmates completed the program successfully or unsuccessfully over time. In fact, the total number of BRC Bridges program participants since inception cannot be validated. The only potential source for determining total inmates who have walked through the BRC Bridges program door was from the BRC Student Records database. The Hacienda School District maintains the BRC Database, but due to system errors in the month of April 2001, HLPSD management was concerned about the accuracy of the database and therefore would not send us the database for our audit. The BRC staff did run a crude and simplified query of the BRC Student Records Database to find a total of 804 inmates that have participated in the program from July 1999 through February 2002. Of the estimated 804 participants:

- 59% (474) have graduated, and
- 20% (159) have been "rolled up" (dropped from the program)

It is unclear from this simplified query what happened to the other 171 inmates. Some potential problems with the data could be duplicate records and/or incomplete records; or, the 171 inmates may not have graduated from the program prior to being released.

Of the estimated 804 inmates:

- 10% (79) received Drug Education certificates
- 39% (317) received Job Readiness certificates
- 35% (279) received Parenting certificates
- 2% (19) received GED certificates
- 0.7% (6) received high school diplomas
- 2% (16) re-entered the program
  - 12 were re-arrested and returned; 4 returned after a medical issue

In addition to the BRC Student Database query, we sampled 100 BRC Student Records and similarly found that the BRC Bridges program completion rate is high. Based on the sample review of 100 BRC Student Records:

An estimated 44% of program participants graduated, of which:
- 20 graduates did not have a release or drop date completed.
- 13 had a drop date.
- 9 had a release reason of "released" but no release date.
- 2 were "rolled-up" (dismissed due to rule violations) from the program after graduation.

- An estimated 44% were released from corrections prior to graduating, of which:
  - 26 had a completed released date.
  - 11 had a release reason of "released" but no release date.
  - 7 were "rolled-up."

- An estimated 12% had no dates completed (potentially still active or release, drop, or graduation dates were unknown).

In terms of certificates received:

- An estimated 48% of the program participants received at least one certificate.

- An estimated 13% received more than one certificate (primarily the Job Readiness Certificate, as well as the Bridges program certificate).

It is important to note that these findings are based on data that may be questionable due to data entry errors. The review of records found a number of records with multiple date entries, such as:

- No consistency between when the release date is completed versus the drop date.
  - Release date is released from any Sheriff's facility, and drop date is released from BRC.
- Release reason completed with no release date.
- Graduation dates completed with no release date or drop dates.
- A number of entry dates with no release, drop or graduation dates completed even with two year old entry dates

The extent of data errors in the BRC Student Records Database is unclear. A consistent definition of each date entry field, as well as a consistent protocol for data entry must be established in order to attain a full understanding of program completion rates and reasons.

Although there are potential data validity issues with the BRC Student Database, the finding that the same number of graduates are released as are non-graduates is cause for an extensive review of the selection criteria process established by the Sheriff's Department. The reason for these inmates being released prior to graduation must be explored in order to determine if they are being received at BRC with too little time left on their sentence to complete the 6-week curriculum, if there are barriers (such as language issues, illiteracy, etc.) preventing these inmates from completing the program, if the 6-week course is too short in duration for the inmates to complete the requirements, or other reasons. This investigation will assist the Hacienda La Puente staff and Sheriff's staff in improving the program curriculum and selection criteria.

RECIDIVISM

As noted above, a primary analysis of recidivism data could not be conducted for this audit due to the lack of consistent and validated program participant and graduation data, lack of key identifying information of program participants and graduates and the delays in receiving responses to the audit data requests. A secondary review of the two recidivism studies conducted by the Correctional Services Division is described below.

December 2000 Preliminary Recidivism Data BRC Bridges to Recovery

This study is based on a one-day snapshot in December 2000. The Correctional Services Division took the 129 graduates to date, the 107 non-graduates and a 116-comparison group to determine those re-arrested and re-convicted for 273.5 (domestic violence) offenses and non 273.5 (domestic violence) offenses. In the review of criminal histories of 352 inmates, 93 or 26.4% were re-arrested, while 18.6% of program graduates were re-arrested.

The table below summarizes the findings of the study, but it is crucial to note that according to the study findings, *"statistically significant conclusions cannot be drawn from this data*. To generate statistical significance one would need to run statistical analyses and these numbers represent mere percentages of the various study groups who were deemed recidivists."

TABLE 3:
SUMMARY OF PRELIMINARY RECIDIVISM STUDY RESULTS

	Program Graduates n=129	**Non-Graduates n=107**	**Comparison Group n=116**
Re-arrests	18.6% (24)	24.2% (26)	37.1% (43)
273.5 offenses	7% (9)	10.3% (11)	12.1% (14)
non-273.5 offenses	11.6% (15)	14% (15)	25% (29)
Re-convictions	8.5% (11)	13.1% (14)	26.7% (31)
273.5 offenses	3.9% (5)	5.6% (6)	12.1% (14)
non-273.5 offenses	4.6% (6)	7.5% (8)	14.7% (17)

Additional limitations of this research include the lack of stratification for the subject data based on the period since release. There were individuals who had been released one year prior to the study period, mixed with those who had been released only three months prior to the study period. Also, after researching the original methodology, the Correctional Services Division discovered that the comparison group was not a "true" comparison group. Approximately, 20% did jail time and of those who did, the conviction was not necessarily 273.5 offenses. Also, the average length of stay for the comparison group was 13 days, which was not the length for the BRC group. The complete recidivism data findings are presented in Attachment 5.

MARCH 2002 RECIDIVISM STUDY OF BRC GRADUATES

This second Corrections Services Division recidivism report on the Bridges to Recovery Program is a more statistically sound time series analysis of recidivism than the initial December 2000 report above. However, a number of potential data issues may exist in these findings as well, such as data entry errors in the data analysis spreadsheets. There are a number of blank entries for the re-arrest yes or no fields. Although the analysis requires a "2" for no re-arrest, the data summarized below assumed that the blank entries were "no re-arrest" as well. This is only an assumption that has not been validated and therefore, the data below may not be accurate. The Correctional Services Division was unable to respond to our inquiries of these potential data errors in a timely enough manner to include in this report.

The study is based on a sample of 229 graduates from June 1999 through July 2001. The re-arrest and re-conviction rates are based statewide California arrest and conviction data for the program graduates.

Recidivism within four distinct timeframes

The table below demonstrates the March 2002 recidivism study findings of the Bridges to Recovery program. The study is based on a sample of 229 graduates from June 1999 through July 2001. Based on graduation dates, the sample size of graduates decreases as the follow-up period/post release increases because the sample below is not cumulative over time; it is divided into four distinct timeframes.

TABLE 4:
SUMMARY OF MARCH 2002 RECIDIVISM STUDY RESULTS

Recidivism for distinct timeframes	**30-day Post release n=229**	**30-60 days Post-release n=220**	**60days–6 months Post release n=179**	**6 months-1 year Post-release n=107**
Re-arrest	4.8% (11)	4.5% (10)	15.1% (27)	15.9% (17)
Violent Offenses **Drug/Alcohol** **Property Crimes** **Weapon Offenses** **Probation Violation**	2.2% (5) 0.9% (2) 0.9% (2) n/a 0.9% (2)	2.3% (5) 0.9% (2) n/a 0.9% (2) 0.5% (1)	6.7% (12) 6.7% (12) 0.6% (1) n/a 1.1% (2)	4.7% (5) 7.5% (8) 2.8% (3) n/a 0.9% (1)
Misdemeanor **Felony**	3.1% (7) 1.7% (4)	3.2% (7) 1.4% (3)	10.1% (18) 5% (9)	11.2% (12) 4.7% (5)
Conviction	3.1% (7)	1.4% (3)	5% (9)	8.4% (9)

From the distinct timeframes of 0-30 days; 30-60 days; 60 days-6 months and 6 months to 1 year, the recidivism rates increase significantly (more than double) from the 30-60 day timeframe and the 60-day to 6-month timeframe. The graduate conviction rates also increase with time. However, the percentage of re-arrests that are convicted actually spikes in the first and last timeframes:

- 64% of the 30-day post release re-arrests are convicted
- 30% of the 30-60 day post-release re-arrests are convicted
- 33% of the 60-day to 6 month post release re-arrests are convicted
- 53% of the 6-month to 1 year post release re-arrests are convicted

Recidivism for graduates who have been released for at least 1 year

Another method for determining recidivism rates is to look at the graduates over the span of one cumulative year (not just within each of the four distinct timeframes). This cumulative one-year analysis of the 107 graduates who have been released for at least one year demonstrates a higher rate of re-arrest, a 32.7% cumulative rate of recidivism (35 of the 107 graduates). Six of those 35 participants had been arrested twice. Therefore the cumulative 1-year recidivism rate by actual cases of re-arrest was 38.32% (41 graduates).

The majority of the one-year post release recidivists were Hispanic (51%), followed by African American (29%) and Caucasian (20%).

Cumulative Recidivism over the span of one-year (regardless of the length of post-release)

A third method of analyzing recidivism is to view the entire sample size of 229 graduates, and determine how many were re-arrested in the course of up to one year following release. In this analysis, the graduate does not have to be released for the entire year, but has to be released for some portion (1 day or more) of the follow-up year. This method helps determine a baseline for the lowest recidivism rates for the graduates. From that baseline the recidivism rates can only increase as the graduates continue to add to their post-release days, and potentially recidivate even more as they progress beyond the 1-year follow-up date.

Of the total 229 graduate sampling size, there were a total of 57 graduates (24.9%), who may or may not have reached a year of post-release, but were re-arrested at some point during that follow-up year. Eight of the graduates (3.5%) were arrested twice, for a total of 65 re-arrests. On average, there were 0.28 arrests per graduate. Almost half (43%) of the individuals who were re-arrested are convicted.

TABLE 5:
SUMMARY OF RECIDIVISM FOR BRIDGES TO RECOVERY GRADUATES

Average arrests per graduate	**0.28**
Percent of graduates re-arrested at some point over the course of a year (n=229) **Cumulative year conviction rate (n=229)**	**24.9%** **12%**
Percent of graduates re-arrested more than once (n=229)	**3.5%**
Percent of graduates re-arrested who have been released for at least one year (n=107) **One-year post release conviction rate (n=107)**	**32.7%** **16.8%**

These 65 cumulative re-arrests are distributed evenly among Drug and Alcohol Offenses and Violent Offenses. The offense breakdown is:

- 42% are Violent Offenses
- 38% are Drug/Alcohol related offenses
- 9% are Probation Violations
- 9% are Property Crimes
- 2% are Weapons Offenses

The majority of the offenders, who had multiple re-arrests, were re-arrested for some combination of Violent and Drug Offenses.

Unfortunately, the data provided for this study did not distribute these re-arrests by domestic violence related offenses. Given that the primary goal of the Bridges to Recovery Program is to decrease the domestic violence offending of its participants, an analysis of domestic violence re-arrests should be conducted to determine program effectiveness.

Although Hispanics represent the majority of the recidivists (54%), they are no more likely to recidivate than African Americans or Caucasians. In fact, Hispanics are less likely to recidivate:

- 24% of the 131 Hispanic graduates were re-arrested
- 28% of the 43 Caucasian graduates were re-arrested
- 29% of the 49 African American graduates were re-arrested

The average age of the recidivates is 36.2 years old, but the 30 year-olds are less likely to recidivate than the 50 year-olds, according to the analyzed sample size.

- 19% of the graduates in their 30's were re-arrested
- 26% of the graduates in their 40's were re-arrested
- 27% of the graduates in their 50's were re-arrested
- 30% of the graduates in their 20's were re-arrested

Comparisons and Patterns

Comparison recidivism rate findings were not available for this study. Due to the delays in obtaining data on BRC Bridges graduates, we were unable to submit a timely data request for to the Probation Department for a comparison group analyses. Evaluating a valid comparison group will be a crucial component for future outcome program evaluations. In order to determine program success, a comparison group must be measured. In addition data on length of sentence was not captured. This information could assist in drawing conclusions about the effectiveness of keeping inmates longer than the program curriculum requires.

Nationally, recidivism is utilized by most criminal justice programs as a key measure for determining success. The numbers vary drastically. A review of over 100,000 state prisoners found that 62.5% were re-arrested for a felony or serious misdemeanor within 3 years, 46.8% were re-convicted and 41.4% returned to prison or jail. More recently, the recidivism rate for offenders charged with drug-related crimes was reported to vary from 50% to 80%. The National Institute of Corrections estimates that the recidivism rate for sex offenders is 60%.

It is difficult to draw any comparisons to these broad and diverse recidivism figures that are defined differently and based on different focus groups and timeframes. The only true way to determine effectiveness is to measure the Bridges to Recovery recidivism rates against a statistically appropriate comparison group within Los Angeles County.

A notable pattern throughout the three different analyses of the 229 graduate data is that graduates continue to be arrested and re-arrested at a fairly consistent rate for up to one year after graduation. This suggests that a coordinated aftercare program may be appropriate. Unfortunately, the number of post-release probationers is not tracked for Bridges to Recovery Program participants; and, due to the delays in receiving data, we were unable to submit a data request to Probation to determine the percentage of Bridges to Recovery participants who are on Probation. Currently, the Bridges to Recovery program has no link to the Probation Department. The Probation Department cannot determine who attends the Bridges to Recovery Program, and BRC cannot determine who is on probation. The Los Angeles County Probation Department does have a Domestic Violence Monitoring Unit that approves and monitors the current 146 domestic violent programs that provide the 52-week classes to domestic violent offenders. Those domestic violent offenders, however, can be in any unit or any caseload.

RECOMMENDED IMPROVEMENTS TO OUTCOME ANALYSES

The development of expected outcomes and measurements must be developed by the BRC Bridges Program in order to determine program effectiveness. The March 2002 Correctional Services Division recidivism study has developed a good starting point for analyzing the program success of Bridges to Recovery. However, a number of additional analyses must take place, including:

- A validated comparison group study;
- An analysis of the type of re-arrest offense in relation to domestic violence;
- An analysis of the length of stay on recidivism and graduation;
- An analysis of the impact probation may have on the recidivism rates; and,

- An analysis of the impact a 52-week domestic violence program may have on the recidivism rates.

In order to measure program effectiveness and program success, quantifiable measures must be established based on program goals and objectives. The first step for the Bridges to Recovery Program is to develop those goals and objectives and align them with measurable performance and outcome indicators.

These indicators will need to be captured consistently, ideally in one central system. The Hacienda BRC Student Records Database seems like the most logical system to capture the necessary data. At the very minimum, entry dates, release dates, and release reasons must be captured consistently.

CONCLUSIONS

This audit was unable to conduct an original analysis of program effectiveness and outcome data due the disparate data source systems and the continuously delayed responses to our data requests. We were unable to get a validated list of program participants and program graduates to track for recidivism analyses. Therefore, the recidivism analysis for this audit is based solely on a secondary review of two studies completed by the Sheriff's Department Correctional Services Division.

The Bridges Program understands the need to track and validate program success. Their first two recidivism studies reflected their understanding of this need. The Correctional Services Division is taking the lead role in beginning to look at program success issues and has reported the need to gather the appropriate data. Some initial steps are being taken in order to track recidivism and other non-quantifiable elements, such as social impacts to success. In order to measure program effectiveness and program success with any validity, however, quantifiable measures must be established based on program goals and objectives. In order for quantifiable measures to be developed, overall program goals and objectives must be determined and must be measurable. The Bridges to Recovery Program lacks measurable and reasonable objectives, methods for measurement, quantifiable performance and outcome indicators, and a consistent method of capturing performance data.

Program effectiveness cannot be determined, even though an estimated 44% to 59% of program participants graduate. An extensive amount of additional data must be consistently captured for all participants in order to obtain a more comprehensive understanding of program results, such as why others did not graduate, release dates and release reasons.

Based on a sample of 229 graduates, the Correctional Services Division Recidivism study of the BRC Bridges program found a 30 day recidivism re-arrest rate of 4.1% and a 1 year cumulative re-arrest rate of 32.71%. Again, these results are inconclusive since additional data, particularly re-arrest of specific domestic violence offense data must be captured and analyzed to confidently determine whether the program impacts the domestic violence behavior of participants.

A notable pattern evident from analysis of the 229 graduate data is that graduates continue to be arrested and re-arrested at a fairly consistent rate for up to the year after graduation. This

suggests that an aftercare program that is coordinated with the Probation Department may be appropriate.

RECOMMENDATIONS

The Sheriff should direct the Correctional Services Division managers to:

4.1 Develop and formalize quantifiable measures of program success, which are directly linked to program goals and objectives. (Recommendation 97)

4.2 Establish consistent methods for capturing performance data. (Recommendation 98)

4.3 Work with the HLPSD to develop additional data elements which will assist with future evaluation of the Bridges to Recovery Program, including the reasons individuals do not graduate, release dates, release reasons, etc. (Recommendation 99)

COSTS AND BENEFITS

There would be no costs to implement these recommendations.

The Sheriff's Department would be better able to assess Bridges to Recovery Program effectiveness

PUBLIC SAFETY COMMITTEE

Application of Law Enforcement

BACKGROUND

The Public Safety Committee of the Los Angeles County Civil Grand Jury 2001-2002 discussed topics of interest for investigation. The Committee chose to study several areas of law enforcement that are currently under public scrutiny. The following report discusses the study.

In the County and the City of Los Angeles, the Los Angeles Sheriff's Department (LASD) and the Los Angeles Police Department (LAPD) are the two main law enforcement agencies. While it is the duty of their officers to protect and serve the public, in some areas of the city and county reports of alleged racial profiling, excessive force, misconduct, and corrupt actions by some officers has caused some mistrust of the police by the people in those communities. It is not uncommon to hear complaints in those communities of drivers being pulled over and searched without apparent reason, making the police suspect of using "racial bias" or "racial profiling."

In some neighborhoods the sale and use of illegal drugs has become a major factor in the increase of crime and gang activity. In an attempt to apprehend the perpetrators, police often use probable cause to search the person and private property of suspects, to look for contraband, and to identify criminals. Because errors can be made, and the rights of citizens violated, it is imperative that police follow proper procedures for search and seizure. Overzealous police who fail to obtain a search warrant may hinder the prosecution of a suspect if they do not follow proper procedures.

The Public Safety Committee decision to study the police pullover technique was also in direct relationship to the areas of concern expressed in the Department of Justice (DOJ) Consent Decree. Following the discovery and disclosure of the LAPD Rampart Area corruption incident, investigation into allegations of police misconduct involving excessive force, false arrests and unreasonable searches and seizures were made against officers of the LAPD.

OBJECTIVE

The objective of the Public Safety Committee of the Los Angeles County Civil Grand Jury 2001-2002 was to investigate certain aspects regarding selective application of law enforcement in the City and County of Los Angeles.

METHODOLOGY

The Committee studied the training and practice of law enforcement personnel, procedures in search and seizure actions, the prohibition of racial bias and profiling as probable cause, and police behavior in pullover stops.

The Committee attended the LAPD recruit officer training classes in the procedures for vehicle pullovers. Committee members participated in LAPD ride-a-longs to observe the officers' actions and behavior in the field. The members rode with patrol units in West Los Angeles, Van Nuys and the City of Gardena. Committee members also attended the LASD recruit officer training classes on search and seizure operations.

The Consent Decree initiated by the Department of Justice, Board of Inquiry Report initiated by the Los Angeles Police Department, Report of the Rampart Independent Review Panel initiated by the Police Commissioners and Chemerinsky Analysis of Board of Inquiry Report initiated by the Los Angeles Police Protective League, were reports which were utilized as study documents for review.

FINDINGS

VEHICLE PULLOVERS – RACIAL BIAS/PROFILE TRAINING

On June 15, 2001 the Consent Decree was formally approved and signed. The Consent Decree consisted of 132 action mandates for the Los Angeles Police Department, mandating changes in a number of Department functions including but not limited to the following:

Community Outreach & Public Information
Investigation of Use of Force
Training
Non-Discrimination Policy and Motor Vehicle & Pedestrian stops
Search and Arrest Procedures

Additionally, the Consent Decree required the Department to collect specific data on vehicle and pedestrian detentions and called for the development of an enhanced risk management system. To date, it is noted that the LAPD Consent Decree Task Force, which was formed for implementation and compliance with the terms of the Consent Decree, has developed and implemented a Department policy prohibiting racial profiling. The Consent Decree is in effect for five years. The Department must demonstrate substantial compliance with and maintain those compliance efforts for an additional two years.

The Public Safety Committee of the Los Angeles County Civil Grand Jury 2001-2002 attended the LAPD Vehicle Pullover Class as observers. Discussed in that class were the three reasons for which the police might instruct drivers to pull over:

To question a driver regarding a current traffic violation;

To investigate occupants of a vehicle regarding suspected misdemeanor behavior; and

To investigate occupants of a vehicle who are suspected of being "high risk" – which necessitates an officer call for backup.

The Public Safety Committee observed the LAPD training class to be a detailed and thorough training in the procedures for vehicle pullovers. Training emphasized the specific criteria used in making pullovers. Due to the charges of "racial bias" and the issue of disparate treatment of minorities by law enforcement officers, techniques in training are increasing and addressing a higher standard for fair and impartial implementation of pullover criteria. All pullovers require new and extensive responsibility and accountability on the part of the officers. Increased data gathering information regarding the profiling of investigatory stops is now required by the LAPD.

It was found that a newly implemented policy by the LAPD for the collection of data regarding investigatory stops has been effectuated. However, in order to implement the mandates of the Consent Decree provision regarding the capturing of field data, equipment and technology not yet available to the LAPD is required. This additional equipment and technology must now be considered in an already greatly constrained budget. Financial implications will greatly affect compliance in this area.

All the rules, procedures, collection of data, report writing, and implementation of procedures still do nothing to address the fact that subjective human decision making drives the selection of investigatory stops. There must be established, after sound criteria, a placement of the highest trust in the law enforcement officers whose duty it is to protect and serve. In order to award this trust relationship, the highest degree of work ethic must be demonstrated by the department and perceived by the public. It is therefore incumbent on the LAPD to maintain the utmost integrity in hiring practices to attract and retain the best and most qualified candidates possible as police officers for the department. Likewise, it is in the best interest of the department and public to continue inclusive hiring practices of racial/ethnic, gender and sexual orientation to best model the communities in which the department will serve.

SEARCH AND SEIZURE TRAINING

The Public Safety Committee members also attended continuing education training classes for the Los Angeles Sheriff's Department regarding search and seizure. These classes were also found to be equally detailed and thorough in officer training and education. The classes covered the proper legal procedures for having search warrants issued, the procedures for the seizure of personal property, and the proper way to carry out an investigation, including the gathering of evidence.

It was emphasized in these classes, that the laws regarding search and seizure are constantly changing and have been reinterpreted by the courts. This has necessitated continuous follow-up retraining for police personnel.

The Public Safety Committee, along with the entire Civil Grand Jury, visited and observed both the Los Angeles Police Department and Los Angeles Sheriff's Department crime laboratories where evidence collected at the scene of a crime is studied, and if necessary, stored. These crime laboratories are not to be confused with the LAPD evidence locker which contains narcotics seized in the commission of crimes.

MEDIATION AND DISPUTE RESOLUTION SKILLS

It appeared that development and training for department sworn personnel continued to be emphasized by the LAPD in a dual effort to provide continuing education and to realize the mandates of a community policing philosophy as suggested in the Consent Decree, Board of Inquiry Report and other reports. The LAPD recognized the importance of providing employees with educational growth opportunities, and also, the importance of sensitivity of employees to understanding the diverse communities served by the department.

Curriculum and training models for the domestic violence training program included an emphasis on the identification of the primary aggressor at the scene of a domestic violence incident. The department proposed legislation in February 1998, that was introduced as Senate Bill 1470 (Thompson) and Assembly Bill 1767 (Havice). These Bills were passed and became effective January 1, 1999. They amended California Penal Code Sections 243 and 836, which authorized a peace officer to arrest, without a warrant, a person who commits assault or battery upon his or her domestic partner. These laws provide additional tools for law enforcement to address the serious problem of domestic violence.

During the LAPD ride-a-long in the Van Nuys area, the Public Safety Committee members observed the officers in the course of their field work. Dispute resolution skills were utilized more often than the public's perception of crime prevention and apprehension. It would seem that a large portion of police work is spent providing and practicing conflict management and mediation as an alternate to the common perception of policing and arresting. Human compassion and understanding, common sense and an adherence to the legal parameters of good citizenship were skills and tools drawn upon by officers answering calls for police response. The police act as family counselors in domestic situations involving couples, or between parents and children. As an example, during the course of the ride-a-long police officers discovered two young children left alone at home that may have been the subject of parental neglect. The children were taken to the local police station.

During a Gardena Police Department ride-a-long, the officers answered a domestic violence call concerning a woman and a man whom she wanted removed from the residence. The Public Safety Committee members observed police officers' interaction with the woman who placed the call requesting police assistance. Upon arrival the man had already left the premise. Social-

work intervention skills were required on the part of the police officers to communicate measures and techniques of safety of the woman.

Later the Public Safety Committee observed the Gardena police officers arrest a woman for selling drugs while parked at a liquor store parking lot. She had driven there with a child who was left in the car while the woman "conducted her business." The police officers realized the minor child was not restrained in a proper car seat and called to have a child's car seat brought to the scene. They proceeded with their investigation and arrest of the woman. The woman's car was impounded and the child was transported to the police station, where the grandmother of the minor child later took custody of the infant.

It was reported to the Public Safety Committee that much of police work was routine policing and a large part of time was spent in writing a report of each incident responded to. A ride-a-long in West Los Angeles, however, was not routine for the Committee members who were returned to the police station so that officers could respond to a bank robbery.

PUBLIC SAFETY COMMITTEE

VEHICLE PULLOVERS – RACIAL BIAS/PROFILE TRAINING
SEARCH AND SEIZURE TRAINING
MEDIATION AND DISPUTE RESOLUTION SKILLS TRAINING

RECOMMENDATIONS

100. The Public Safety Committee recommends that the Los Angeles Police department and Los Angeles Sheriff's Department should continue their education and training programs in areas of officer's interaction with the public and treatment of crime suspects and prisoners.

101. The Public Safety Committee recommends that the Los Angeles Police Department and Los Angeles Sheriff's Department should continue to provide follow up training as the evolution of case law may dictate, particularly in the area of search and seizure.

102. The Public Safety Committee recommends that the Los Angeles Police Department and Los Angeles Sheriff's Department should continue to emphasize and provide continuing education in the specialized areas of dispute resolution, conflict management and mediation in an effort to seek constantly alternate ways of establishing positive communication while upholding the Vision, Mission and Core Values of the Departments.

103. The Public Safety Committee recommends that the Los Angeles Police Department should continue its attention to implement the terms and conditions of the Department of Justice Consent Decree document which was mutually agreed upon, formally approved and signed on June 15, 2001.

RESEARCH AND FOLLOW-UP COMMITTEE

BACKGROUND:

The Los Angeles County Civil Grand Jury investigates Los Angeles County agencies and makes recommendations to these agencies designed to improve their performances. All agencies to whom recommendations are made are directed to reply, according to California Penal Code §933(c):

> "No later than 90 days after the grand jury submits a final report on the operations of any public agency subject to its reviewing authority, the governing body of the public agency shall comment to the presiding judge of the superior court on the findings and recommendations pertaining to matters under the control of the governing body, and every elected county officer or agency head for which the grand jury has responsibility pursuant to Section 914.1 shall comment within 60 days to the presiding judge of the superior court, with an information copy sent to the board of supervisors on the findings and recommendations pertaining to matters under the control of that county officer or agency head and any agency or agencies which that officer or agency head supervises or controls. In any city and county, the mayor shall also comment on the findings and recommendations. All of these comments and reports shall forthwith be submitted to the presiding judge of the superior court who impaneled the grand jury. A copy of all responses to grand jury reports shall be placed on file with the clerk of the public agency and the office of the county clerk, or the mayor when applicable, and shall remain on file in those offices. One copy shall be placed on file with the applicable grand jury final report by, and in the control of, the currently impaneled grand jury, where it shall be maintained for a minimum of five years."

The responses to the recommendations of the outgoing Civil Grand Jury are received by the incoming Civil Grand Jury usually during the first three months of its term of service. It is the function of the research and Follow-Up Committee of the Los Angeles County Civil Grand Jury to match the recommendations of the previous grand jury to the responses made by the agencies which were addressed.

A match-up of all recommendations in the final report(s) for a given year constitutes a one-year data base of recommendations and responses. Such a database supplies significant information to the Civil Grand Jury and is of help to subsequent Civil Grand Juries in their determination of the line(s) of investigation they might want to follow. This database is to be kept by the grand jury for a minimum of five years.

The second year, if this process is repeated, the new database may be added to the first. By the time the first database has been held five years, there would have been developed a five-year database of recommendations and their respective responses. This collected information could be of great value to each incoming Civil Grand Jury.

Unfortunately, the Civil Grand Jury is not a continuous body. Under present law, the Civil Grand Jury exists for one year only, from July 1 to the succeeding June 30. Therefore, the Civil Grand Jury cannot keep anything for more than twelve months, and in the case of incoming responses, only nine months, or less, if the delivery of the current responses to the grand jury is delayed.

For the grand jury to carry out its mandate regarding the five-year retention of the recommendation/response database, some carry-over in membership from one Civil Grand Jury to the next would be helpful. While it is possible for a few members to be held over for several months by the presiding judge, this option has rarely been exercised. Unless exercised on a regular basis, it would not solve the problem of the Civil Grand Jury's holding anything for a minimum of five years.

Other than through a final report there is no communication from one Civil Grand Jury to the next. A five year data base of recommendations and appropriate responses is too voluminous a document to be included in a final report. The inclusion of only the current year's one-year database would fail to follow the requirement to "keep five years" for the four years preceding the kept database. Also, since responses are not made anonymously, and since the anonymity of sources of information in the final report is highly desirable, there is the difficult problem of concealing the identity of the people making the responses.

While the Foreperson of a Civil Grand Jury addresses his succeeding Civil Grand Jury during the members' orientation, and while he/she could carry a five year recommendation/response database with him/her to leave with his/her successors, this procedure would be regularly endangered by the possibility of an emergency arising to prevent the Foreperson's meeting with the new Civil Grand Jury members during their orientation.

The Los Angeles County Civil Grand Jury Staff is a continuing organization and is in the process of establishing an area for a library, preferably a place which may be locked, in which important documents may be secured, and which may be made available, when requested, to members of an impaneled Civil Grand Jury. While this Civil Grand Jury would be responsible during its year of service for "maintaining" the database reports in an up-to-date condition, the Grand Jury Staff would be responsible for the "control" (through filing) of these databases on a continuous basis, at least "for a minimum of five years."

In August, 1998, Assembly Bill No. 1907 was passed, amending sections 924.4, 933 and 934 of the Penal Code. Legislative Counsel's Digest reads:

> "(1)Existing law authorizes the grand jury to transmit to the succeeding grand jury, any information or evidence acquired during the course of any investigation conducted by it, except any information that relates to a criminal investigation or that could form part or all of the basis for the issuance of an indictment."

Since the recommendations and responses are simply parts of documents which have already been released to the public, they should not be restricted for this reason. The Legislative Counsel's Digest continues:

> "This bill would clarify that the grand jury is authorized to provide the succeeding grand jury with any records, information, or evidence acquired by it during its term of service except as stated above.
> (2)Existing law requires a grand jury to submit a report of its findings and recommendations to the presiding judge of the superior court at the end of the fiscal or calendar year, and to file a copy of each report in the office of the county court.
> This bill would require the grand jury also to file in the office of the county clerk, a copy of the responses to the final report. In addition, the bill would require the county clerk to forward a copy of the report and responses to the State Archivist to retain in perpetuity."

A five-year database of recommendations and their appropriate responses would provide help to the committees of a newly impaneled Civil Grand Jury in determining their own study topics. But to date, such information has not been available (v.i., FINDINGS).

OBJECTIVES

The Research and Follow-Up Committee of the Los Angeles County Civil Grand Jury 2001-2002 undertook the following objectives:

1. To construct a five-year database of the recommendations written in the Los Angeles County (Civil) Grand Jury Final Reports of the last five years and to attach the appropriate response, when obtained, to each recommendation,

2. To index this file by date and subject as a convenient reference file for succeeding Los Angeles County Civil Grand Juries,

3. To transmit a copy of the current five-year database, indexed by date, to the county clerk as requested in Assembly bill No. 1907, (This would serve:
   a. to comply with Assembly bill 1907 regarding the current year,

   b. to rectify any omissions by the Civil Grand Jury for the four years preceding, which would back date the responsibility of the grand jury to the date of the Bill, 1998, and
   c. to provide a source from which future Civil Grand Juries might obtain copies of this information when needing to replace copies under the control of the Grand Jury Staff which had been lost or badly worn by usage.)

4. To supply Grand Jury Staff with two copies of the current five-year database, indexed by date and subject, for keeping under their control in a secure library, for use, as needed, by subsequent Civil Grand Juries and any other appropriate personnel,

5. To supply the Foreperson of the Los Angeles County Civil Grand Jury 2001-2002 with a copy of the current five-year database, indexed by date and subject, to transmit to the Los Angeles County Civil Grand Jury 2002-2003 during the orientation of that jury,

6. To copy this five-year database, indexed by date and subject, on a computer disc for use as a back-up file, if needed, and

7. To offer this material for use on the Los Angeles County Grand Jury Website.

METHODOLOGY

The Research and Follow-Up Committee annual reports in the Los Angeles County (Civil) Grand Jury Final Reports for the previous five years were studied to understand the problems those committees had had. Throughout these five final reports, the items listed as recommendations, and statements inferred as recommendations, were separated out and indexed by subject and year.

Agencies, to whom the recommendations were addressed, were contacted, and responses to the specific recommendations were requested. Each response that was returned was combined with its appropriate recommendation, hence also indexed by subject and date.

A copy of the five-year database, indexed by date, i.e., the annual groupings was transmitted to the county clerk.

Two copies of the five-year database, indexed by subject and date, were filed with the Civil Grand Jury Staff for Civil Grand Jury use, to comply with the Penal Code requirement to keep this information "for a minimum of five years," and to provide succeeding Civil Grand Juries with history and information to aid them in choosing their directions of interest.

A copy of the five-year database, indexed by date and subject, was provided to the Foreperson of the Los Angeles County Civil Grand Jury 2001-2002 for transmission to the Los Angeles County Civil Grand Jury 2002-2003 during its orientation, as information for the new group concerning the results of previous (Civil) Grand Jury investigations.

A computer disc was made of the five-year database and stored with the Grand Jury Staff.

The website operator was alerted as to the availability of this material.

FINDINGS:

Various forms of recommendations were found in the final reports:

Recommendations were written, sometimes, intermixed with discussion, and not identified, specifically, as recommendations. Sometimes these recommendations were overlooked by the agency to which they were addressed.

Recommendations were written, sometimes, identified as recommendations, but separated by portions of discussion, making it possible to lose the connection from one recommendation to the next.

Recommendations which were vague or too long did not always elicit a serious response.

Recommendations which did not carefully evaluate large manpower requirements or excessive costs were frequently not considered seriously by the responder.

Recommendations, which were perceived by the responder to be outside the jurisdiction of the Los Angeles County Civil Grand Jury, frequently received a terse non-committal answer.

Most often, the recommendations were clearly written and had merit.

The types of responses varied:

Some recipients of recommendations simply did not respond.

Some recipients of recommendations responded only under pressure. For example, one recipient responded to the recommendations of the Los Angeles County Civil Grand Jury 2000-2001 eight and one-half months after the time limit authorized by the penal code, and then only after legal pressure.

Some responses of the past could not be located.

Sometimes a response seemed to have no relationship to its recommendation.

Most responses indicated that the responders considered the recommendations seriously, pointed out differences of opinions, when present, but, nevertheless, tried to implement the recommendations when possible.

There were findings regarding recommendation/response combinations:

A database, constructed from the specific response to each and every recommendation in the final report for any individual year provided a history of what was studied and what was found. When available it formed a valuable teaching tool and reference point for any impaneled Civil Grand Jury that chose to use it. Much of its value was in helping newly formed committees of a recently impaneled Civil Grand Jury to decide the direction of their own investigations.

The construction of a one-year database of recommendations with their appropriate response was an arduous and time consuming task.

The construction of any such database was usually finished late in the term of the Civil Grand Jury committee that was doing the constructing. Hence, it was of minor value to the Civil Grand Jury involved in its construction. It was most valuable for succeeding Civil Grand Juries for it would be available early in their terms of service.

The construction of a similar database covering five years required much more time and effort. Once constructed, a five-year database provided much more information to a Civil Grand Jury than did a one-year database.

The Los Angeles County Grand Jury 1998-1999 Research and Follow-Up Committee constructed a five-year database 'after a painfully slow, tedious and largely manual research effort on the part of the members of the committee . . . for key recommendations . . . laboriously cross-checking for responses in central files . . . (with) personal and telephone contact work with appropriate agency staff at the County and City level." The Los Angeles County Grand Jury 1998-1999, on its own, purchased and emplaced a computer to maintain these records as an information source for future Los Angeles County Civil Grand Juries. It was important to note that such a historical database was of only marginal use to the grand jury that was constructing it. It was finished too late to help in that grand jury's decision-making regarding what areas to study. The primary

value of such a database was to the members of the next newly impaneled Los Angeles County Grand Jury. Each new jury would be able, through a study of this five-year-spanning file, avoid repetitive investigations and concentrate its own work more efficiently in unstudied areas.

On being impaneled, the Los Angeles County Grand Jury 1999-2000 found only previous final reports with their recommendations. There were no recorded responses. That Grand Jury reported, "Unfortunately, last year's Research and Follow-Up Committee was unable to document their tracking process and, in spite of their laborious cross-checking, left no working data." It thus fell upon the Los Angeles County Grand Jury 1999-2000 Research and Follow-Up Committee to search again for the responses to each of the recommendations of the grand juries of the previous five years, and, if possible, to collate and computerize the data on the new computer. Los Angeles County had many websites on the internet. One was titled Grand Jury Reports (grandjury.co.la.ca.us/gjreports.html). At the time, however, the impaneled Los Angeles County Civil Grand Jury was not authorized to do anything other than read what someone else had placed upon this "Grand Jury Website."

When impaneled, the Los Angeles County Civil Grand Jury 2000-2001 found that the database of recommendations and responses from the Los Angeles County Grand Jury 1999-2000 was no longer available. The Los Angeles County Civil Grand Jury 2000-2001 reported, "The novel task of reviewing the past grand jury recommendations and pursuing the appropriate responses from the agencies targeted was a long and laborious process . . . the purpose . . . is to examine previously studied areas to eliminate duplication of effort . . . and clearly delineate meaningful areas of inquiry." It further recommended the "past Grand Jury recommendations and the appropriate agency responses, should be given to committee chairpersons so they can research a facility before their initial field visits."

This year the Los Angeles County Civil Grand Jury 2001-2002 found, when first impaneled, the final reports, with recommendations, from four of the last five Los Angeles County Grand Juries. There were no records of the agencies' responses. A check of the computer website, revealed only copies of two of the last three Los Angeles County Grand Jury final reports, a portion of a third, a funding report for one of the years and the responses from agencies responsible to the Board of Supervisors for the year 1999-2000.

If the database formed by one grand jury was not transmitted to its successor, and if the successor wished this information, the successor would have to reconstruct the database that had not been transmitted. Committees of each of the grand juries of 1998-1999, 1999-2000, and 2000-2001 constructed databases of the recommendation/response combinations for the five years preceding their term of service. But each year this

information disappeared between the ending of one grand jury and the impanelment of the next, making it necessary for the incoming grand juries of 1999-2000, 2000-2001 and 2001-2002 to reconstruct the "lost" databases. This reconstruction involved a repetitive task which should have been unnecessary. It left the original work as wasted effort.

Omissions of the Penal Code

There is no person designated as responsible for seeing that the various agencies respond to Civil Grand Jury recommendations. Request by Grand Jury Staff to the agencies involved for the responses were not always well received.

There is no person designated as responsible for transmitting to the Civil Grand Jury a copy of the responses to recommendations, when responses have been made.

SOCIAL SERVICES COMMITTEE

MacLaren Children's Center
Management Audit

BACKGROUND

The MacLaren Children's Center has a history of difficulties and controversies with its place in providing social services in Los Angeles County. The Social Services Committee of the Los Angeles County Civil Grand Jury 2001-2002 felt that by auditing specific functions of the operation, it could help pinpoint areas for change that would improve the efficiency of the operation and care of the children at MacLaren Children's Center.

The following is the Management Audit of MacLaren Children's Center prepared by an independent audit firm engaged by the grand jury.

Executive Summary

The Harvey M. Rose Accountancy Corporation was retained by the FY 2001-02 Los Angeles County Civil Grand Jury to conduct a management audit of MacLaren Children's Center. The purpose of the audit was to determine if improvements could be realized in three primary areas of the Center's operations: 1) human resource management particularly background checks for new and existing employees; 2) costs of operations; and, 3) efficiency of use of staff and other resources. A summary of the findings, recommendations and costs and benefits of the recommendations contained in this audit report are as follows. The recommendations are numbered according to their respective sections in this report.

Population Profile

Summary of Findings:

- The population at MacLaren Children's Center is increasingly older and psychologically and emotionally troubled. The majority of children are admitted from psychiatric hospitals, failed placements, juvenile hall or probation, or after running away from the facility. Many are medically fragile, some are developmentally disabled and school achievement of the population as a whole is well below grade level. There was an average of over six serious incident reports every day in 2001 such as children assaulting staff or each other.

- Average length of stay data show there are two groups in the population. The average length of stay for all children was 47.9 days based on all children at the facility on two sample days in 2001. But for the 86 percent of the population who stayed over 30 days, the average length of stay was 89.9 days. 193 children, or 63.7 percent of the 303 children in the sample, had been admitted more than once to MacLaren.

- Core staffing and the approach at MacLaren should be reconsidered given the profile of most of the population residing at the facility. The core staff working with the children now are Children's Social Workers and Group Supervisors. Children's Social Worker training is more geared to case management rather than direct mental health services. A mental health classification such as Licensed Psychiatric Technician would be more appropriate as the core staffing in the cottages who work with MacLaren's population. Reconfiguring core staffing by replacing most direct service Children's Social Workers and Group Supervisors with Licensed Psychiatric Technicians would also lower salary and benefits costs by an estimated $2.6 million per year.

- Approaches such as wraparound should continue to be monitored and expanded to the extent they are proven cost effective. Indications so far at MacLaren is that wraparound can help remove children from the ongoing cycle of stays at MacLaren.

Recommendations

Based on the above findings, it is recommended that Interagency Children's Services Consortium:

2.1 Request that the Director of Mental Health services at MacLaren prepare a proposal for a program to replace Children's Social Workers and Group Supervisors with mental health staff in the cottages to provide a more therapeutic approach appropriate to much of the population at MacLaren; (Recommendation 100)

2.2 Request that the Director of Mental Health services prepare measures of effectiveness or outcomes for review and approval by the Consortium to use in measuring the results of the proposed program; (Recommendation 101)

2.3 After review and approval of the proposal, implement on a pilot basis and measure results to ensure that desired results are achieved or, if not, determine what changes are needed; (Recommendation 102)

2.4 Replicate the program throughout the facility once its effectiveness has been established; and, (Recommendation 103)

2.5 Collect evidence to verify the effectiveness of programs such as wraparound and expand to the extent possible. (Recommendation104)

Costs and Benefits

The benefits of the recommendations above would include a more appropriate mix of staff and approach to dealing with the population as profiled in this report section. Costs would also be lowered as the Psychiatric Technician classification is not paid as highly as Children's Social Workers or Group Supervisors. Assuming 20 percent of the budgeted Children's Social Workers and Group Supervisors were retained and 80 percent replaced with Psychiatric Technicians, salary and benefits costs would be reduced by approximately $2.6 million annually.

Criminal Background Checks at MacLaren

Summary of Findings:

- In August 2001 MacLaren Children's Center became a State licensed facility and subject to California Department of Social Services licensing requirements, including conduct of criminal background checks of all employees working at the facility who have contact with children. The background check includes statewide and national criminal records checks as well as a determination of whether the applicant's name appears on the Child Abuse Central Index.

- In June 2001, in preparation for licensure, MacLaren management began the process of conducting background checks of all employees at the facility. Through this process, MacLaren discovered that 17 employees had previously undisclosed criminal histories considered unacceptable either by CDSS or by a stricter set of standards established by

MacLaren management. In addition, four individuals voluntarily resigned or transferred during the background checks process.

- The newly instituted background checks process appears to be working well for most existing and new MacLaren employees assigned from the Departments of Children and Family Services, Mental Health and Health Services. Of 63 randomly selected employees, clean results were found for 51. For the majority of the remaining 12 employees there were reasonable explanations as to the reason clean results were not documented. No background check documentation was found for Resource Utilization Management unit staff or some contractors who have contact with children.

- The separately administered background check process for Los Angeles County Office of Education (LACOE) employees at the on-site school does not appear to be working as well. Of 30 LACOE employees selected, background checks could be verified for only 10, one of which contained a criminal history with no details available. LACOE was not able to provide background check documentation for any of their contractors working on site. LACOE reports that it has been administering its background check procedures under a different set of regulations than MacLaren and reports that is was not made aware of the new background check policies and procedures implemented at MacLaren until this audit.

Recommendations

It is recommended that MacLaren Children's Center:

3.1 Immediately bring all staff and contractors assigned to the facility who have or could have contact with children there in compliance with CDSS and MacLaren policies regarding background checks; (Recommendation 105)

3.2 Seek an agreement with LACOE regarding the background checks of employees assigned to the MacLaren School, in which LACOE agrees to provide MacLaren with legally certified documentation regarding the results of background checks conducted of LACOE staff. Additionally, LACOE should agree to abide by MacLaren policies regarding background checks for those LACOE staff assigned to the facility. Should such an agreement not prove feasible, then MacLaren should review its options relative to alternative providers of educational services at the facility; (Recommendation 106)

3.3 Clarify the California laws and regulations regarding the storage of criminal background checks. Work to ensure that criminal background checks record-keeping is consistent for all employees assigned at MacLaren and that records are auditable; (Recommendation 107)

3.4 Document its policies and procedures relative to background checks and ensure that all County agencies and other parties operating at the facility are aware of these policies and procedures and are in compliance with them; and, (Recommendation 108)

3.5 Document background checks conducted for all contractors and their employees operating at the facility, including those contracted with by DCFS, DMH, DHS and LACOE. (Recommendation 109)

It is recommended that LACOE:

3.6 Immediately conduct background checks on those employees assigned to MacLaren who have not undergone a background check, and document the results of all background checks conducted, with a legal certification as to the truth and accuracy of the information. (Recommendation 110)

Costs and Benefits

The majority of the recommendations above falls under the overall responsibilities of existing staff, and should not generate additional costs for the facility. The one exception is that the cost of some contractor background checks may need to be borne by MacLaren; however, in general this cost is negligible, relative to the benefit of knowing that only the most qualified staff and contractors have access to the children at the facility. Also, future contractors could be required to have their staffs undergo the background checks before being assigned to MacLaren.

Investigating Allegations of Abuse By Staff

Summary of Findings:

- MacLaren has a number of policies and procedures related to reporting incidents that occur at the facility, including allegations of abuse by staff against children. These policies and procedures are not up-to-date and do not accurately reflect how various incidents are handled at the facility.

- A backlog going back to 1997 was found for DCFS investigations of allegations of abuse by staff against children. This backlog has increased over the past two years. DCFS staff report that the reason for the backlog is insufficient staffing and an increase in the number of child deaths elsewhere that required investigation. This backlog situation is critical because it could: 1) result in great harm coming to children at the facility; 2) put the County at risk of lawsuits; 3) give staff the impression that there will be little consequence for abusive behavior toward children, and thus increase the likelihood of future abuse; and 4) cause children to become discouraged and believe that there is no point in reporting the abuse. To improve this situation, DCFS recently assigned a dedicated investigator to MacLaren.

- MacLaren's internal staff investigations are conducted by coworkers and have been characterized by staff as perfunctory at best. To ensure the independence and effectiveness of internal investigations, MacLaren needs one individual whose primary responsibility is the investigation of allegations of abuse by staff against children. This position should report directly to the Administrator, and should be required to provide the Administrator with quarterly reports regarding the status and outcomes of investigations. This investigative position should replace the internal investigative responsibilities

currently assigned to Children's Services Administrators (CSAs) at the facility. Policies and procedures regarding special incident investigations should be updated to reflect CDSS regulations and other changes made to improve the process, and staff should be trained regarding these updated policies.

Recommendations

Based on the findings above, it is recommended that the MacLaren Children's Center Administrator:

4.1 Relieve the Children's Services Administrators (CSA's) currently conducting the preliminary investigations of this duty, as their positions and reporting relationships do not provide the independence necessary to perform this function effectively; (Recommendation 111)

4.2 Assign a manager, preferably one with investigations/auditing skills, to focus primarily on investigations of allegations of abuse by staff against children at the facility. This individual should have complete independence and autonomy from all other managers and staff at the facility and should report directly to the Administrator; (Recommendation 112)

4.3 Direct the new investigator to conduct timely investigations and prepare timely, complete and accurate reports and to produce a quarterly report to be presented to the Administrator regarding the status and outcomes of activities in this area for that quarter; (Recommendation 113)

4.4 Use the quarterly as well as individual investigations reports to ensure that the investigations are being managed in a timely and effective fashion, and problems corrected; and, (Recommendation 114)

4.5 Update MacLaren's policies and procedures relative to Special Incident reporting, including the timeframes and documentation component, and key personnel involved in the process. The policies also should address the code of silence among staff, and put forth concrete consequences for anyone found to have obstructed an investigation of allegations of abuse by staff against children at the facility. This update should include a training element, during which staff are instructed on the policies and procedures and about the importance of timely and proper documentation. (Recommendation 115)

It is recommended that the Interagency Children's Services Consortium:

4.6 Direct DCFS to continue to address the investigation backlog and give it the highest priority. DCFS should be instructed to report back to the Consortium within six months as to the status of the backlog. (Recommendation 116)

Costs and Benefits

The primary additional costs associated with this recommendation are the salary and benefits costs of the Children's Services Administrator assigned to conduct investigations of allegations of abuse by staff against children. This cost ranges from approximately $70,000 to $115,000 annually[1]. This cost should be at least partially, if not fully, offset by reductions in CSA staff time now spent on internal investigations. The benefits gained by keeping up to date with such investigations, including preventing harm to children at the facility and decreasing the risk of lawsuits, far outweigh any incremental costs. Existing staff could potentially be reassigned to this function to avoid hiring new staff.

Recruitment, Hiring and Item Control

Summary of Findings:

- The decentralized nature of human resources management at MacLaren has led to complications and inefficiencies, and illustrates the difficulty in trying to provide integrated services by various County departments and agencies. Additionally, the Consortium Operational Agreement contains many provisions that limit the Administrator's authority to the detriment of overall effectiveness in managing the human resources function.

- Examples of difficulties experienced as a result of decentralized human resources management include the lack of direct input by the Administrator into hiring decisions of LACOE staff assigned at MacLaren; high turnover in key management positions in the Health Services function; disagreement regarding reporting relationships and roles and responsibilities of key management positions in the Health Services function; disagreement regarding the hiring and management of nursing staff; and a lack of accurate item, or position, control data that would enable management to account for all staff at the facility at any given time.

- The MacLaren Administrator needs final decision making authority regarding the staffing types and levels at the facility, as well as disciplinary authority. This would increase the efficiency and effectiveness of the overall operation as it would centralize authority and responsibility for key human resources decisions, the major element driving operations at MacLaren.

Recommendations

It is recommended that the Interagency Children's Services Consortium:

5.1 Increase accountability and overall efficiency and effectiveness at MacLaren by revising the Operational Agreement to include more specific and detailed agreements with all parties assigned to the facility, giving the MacLaren Administrator final decision making

[1] These figures are based on salary and benefits ranges for the CSAI through CSAIII classifications, and assume a 30 percent benefits ratio.

authority as to staffing types and levels at the facility, including disciplinary actions up to and including dismissal from the facility; (Recommendation 117)

5.2 In areas in which specific expertise is required to make efficient and effective staffing decisions, MacLaren should have its own experts, either on staff or as consultants, who can advise management as to the best configuration; (Recommendation 118)

5.3 Review options for using non-County service providers who are more able or willing to work within the proposed management framework and transfer current County costs to that provider from the department or agency in question should one of the entities be unable or not wish to participate in the recommended amendments to the Operational Agreement; (Recommendation 119)

5.4 Require staff from all agencies to report monthly to the Human Resources Director at MacLaren regarding the total staffing from their department, including new hires, resignations, terminations and transfers. Those agencies not complying with this requirement should be reviewed for suitability to continue their assignment at the facility. (Recommendation 120)

Costs and Benefits

The primary costs associated with the above recommendations relate to the expertise that might be required to provide MacLaren administration with the appropriate analyses and recommendations regarding staffing at MacLaren. However, it is quite possible that such expertise could actually lead to a net reduction in costs for the County, because of savings associated with different staffing configurations.

The key benefit of the recommendations is that they would lead to more accountability at the facility. By giving the Administrator the authority over all personnel decisions at the facility, the County would also be vesting all responsibility for these decisions with the Administrator. This should lead to increased efficiency and effectiveness at MacLaren.

Cost/Staffing Analysis

Summary of Findings:

- MacLaren Children's Center is a very high cost facility that serves children with great needs. But management does not have control over or complete information about total costs at the facility. Nor are systems in place for measuring the outcomes when new services or staff are added. Without such measurement and without basic financial information, MacLaren management is not accountable for total facility costs nor in a position to assess the effectiveness of services provided relative to costs to ensure that it is providing the most effective services to its residents for the dollars spent.

- By extracting information from each agency's financial system for this management audit, consolidated actual MacLaren expenditures in FY 2000-01 were identified as $37,713,970 or $728 per child per day. For the current fiscal year, 2001-02, total costs are

projected to be approximately $41.2 million, or $757 per child per day and $276,305 per child per year. Costs are expected to be even higher in FY 2002-03 based on preliminary budget proposals which call for more new positions and other increases beyond cost of living adjustments. The Department of Children and Family Services' share of the cost per child per day is approximately $471. In comparison, the same cost for the Children's Shelter in Santa Clara County which has a similar population mix and size, is approximately $250 per day.

- The Interagency Children's Services Consortium has given the MacLaren Administrator authority over all operations at the facility but this authority has not been accompanied by financial control or basic financial information needed to make management decisions. Expenditure levels for three of the four agencies at MacLaren are decided by the parent agencies themselves, not MacLaren management. None of the three agencies report their actual expenditures to MacLaren management. As a result, decisions regarding staffing, service levels and other aspects of operating the facility such as procurements are made without appropriate fiscal consideration by MacLaren management. Contracting for services should be considered as one means of gaining control over service levels and costs.

Recommendations

Based on the above findings, it is recommended that the Interagency Children's Services Consortium:

6.1 Direct staff to develop a cost tracking and reporting system so that all budget and actual expenditures are consolidated, reviewed and approved by the MacLaren Administrator and reported to the Consortium; (Recommendation 121)

6.2 Direct staff to delegate authority over funding and service levels for all services at MacLaren to the Administrator; (Recommendation 122)

6.3 Revise procurement policies so that the Administrator is responsible and accountable for all procurement at MacLaren; (Recommendation 123)

6.4 Direct staff to design and implement performance measurement systems for measuring outcomes of existing and any new proposed staffing or services; (Recommendation 124)

6.5 Consider alternative staffing levels and approaches to obtain desired outcomes including eliminating barriers between agencies so that managers can assume responsibility for staff from different agencies and the number of managers can be reduced; (Recommendation 125)

6.6 Consider and obtain comparative cost information for contracting for services now provided by various County agencies if they are unwilling to relinquish control over service and staffing levels to the MacLaren Administrator; (Recommendation 126)

6.7 Establish a policy of reducing costs in the parent agencies when administrative functions are transferred to MacLaren; and, (Recommendation 127)

6.8 Obtain comparative cost information regarding contracting for all services at MacLaren. (Recommendation 128)

Costs and Benefits

Greater fiscal responsibility and cost effectiveness should result from the above recommendations. There would be no new direct costs associated with implementation of these recommendations.

1. Introduction

PURPOSE AND NEW STRUCTURE OF MACLAREN CHILDREN'S CENTER

MacLaren Children's Center was originally designed as an emergency or temporary holding facility for children taken from their families in cases of abuse, neglect or abandonment. The role of the Center is to house these children until such time as they can be reunited with their families or move to a more long term placement such as staying with relatives, a foster family or in a group home.

Previously a unit of the Department of Children and Family Services (DCFS), the structure of MacLaren was changed in 1998 when it was placed under the jurisdiction of a new County Interagency Children's Services Consortium. The Consortium is comprised of the County's Chief Administrative Officer and the heads of the key agencies that provide services to the children who reside at MacLaren: DCFS; the Department of Health Services; the Department of Mental Health; the Probation Department; the Department of Public Social Services, and Los Angeles County Office of Education. Prior to creation of the Consortium, DCFS had primary responsibility for operating MacLaren. The Departments of Health Services and Mental Health were responsible for providing their services to MacLaren residents, although their staff assigned to the facility were organizationally separate from DCFS. Similarly, the Los Angeles County Office of Education operated the on site school at MacLaren but the staff at the school were independent of DCFS.

While all of the agencies located at MacLaren had to coordinate their services to some extent, many observers believed that services at the facility and throughout the child welfare system were not well coordinated and that a key problem facing the Center was fragmentation of services. A 1998 evaluation of MacLaren identified the lack of a coordinated approach to serving the children and their families between the various agencies as one of the major hindrances to MacLaren's effectiveness[1]. The same report also asserted that MacLaren was operating in two irreconcilable roles, as an emergency shelter and as a treatment facility. To address these problems, the report recommended: 1) removing MacLaren from DCFS and making it a separate inter-agency organization comprised of all agencies involved in providing services to MacLaren children; and, 2) refocusing MacLaren as a short term shelter facility and increasing other community-based resources for the long-term treatment component of the County's child welfare system.

The Consortium was created and codified in a Memorandum of Understanding (MOU) entered in to by the agencies listed above in 1998. The MOU gave the Consortium overall authority over MacLaren and established the facility Administrator as their direct report, responsible for insuring coordination and alignment of all MacLaren programs, activities and services. The MOU called for development of a long term intensive care system to

[1] "Brief Facility Assessment of MacLaren Children's Center", prepared by Robert F. Cole, Ph.D., for the Los Angeles County Board of Supervisors, March 23, 1998.

serve MacLaren children and redefined MacLaren's role as an integrated component of this system, but primarily providing short term shelter. Short term was defined in the MOU as less than 30 days. The MOU called for development of outcome criteria and instruments that are concrete and measurable to allow for assessment of program performance.

An Operational Agreement was entered into in 2001 by all members of the Interagency Children's Services Consortium to confirm and define their roles and responsibilities. The Agreement defines the following roles and responsibilities for the signatory agencies:

- Ensure MacLaren Children's Center provides integrated care and planning for children;
- Provide for the successful transition of children from MacLaren to family and/or community living; and
- Develop and implement a community-based long-term intensive care system.

The Operational Agreement more clearly defined the role of the Administrator at MacLaren as the manager to whom all employees at the facility report. This represented a change from the previous organization structure in which an administrator was assigned to the facility from DCFS but the employees from the other agencies stationed at MacLaren reported to their own department managers. In the 2001 Agreement, the Administrator, who reports to the Consortium, is given authority over all MacLaren personnel and procurement issues except for evaluation and discipline of medical staff and County Office of Education staff.

Each Consortium member agency is responsible for preparing a separate budget for their MacLaren related costs. All of these budgets are to be consolidated into a single budget for the enterprise and tracked separately from their full departmental budgets.

The intent of the Operational Agreement and the new organization structure is to prevent multiple and extended stays at MacLaren. The goal stated in the document is to transition children out of the facility to a permanent placement within 30 days of admission.

Many of the changes required by the Operational Agreement were being implemented while this audit was in progress. The Consortium was in place and functioning under the direction of the County's Chief Administrative Officer. A permanent facility Administrator in the new role outlined for that position in the Operational Agreement had not yet been appointed but an Interim Administrator was in place during the audit period[2]. Most of the administrative changes required by the Agreement had been at least initiated, though few were completed or in compliance with the timelines specified in the Agreement. The specific responsibilities of the different departments outlined in the

[2] The Interim Administrator was appointed in September, 2001, on loan from the Department of Public Social Services (DPSS). He was subsequently appointed Director of DPSS and assumed that position on March 1, 2002, while the audit field work was still in progress. He was replaced by a second Interim Administrator while the search for a permanent Administrator continued.

Agreement had not all been fulfilled while field work was taking place. However the Interim Administrator and most of the Center's management team were fully committed to the concepts embodied in the Agreement. Many of the details of how to best accomplish those concepts were still to be determined.

The impact and some of the results of the new organization structure and creation of the Consortium is discussed further in the findings of this audit report.

PURPOSE AND SCOPE OF AUDIT

The Harvey M. Rose Accountancy Corporation was retained by the FY 2001-02 Los Angeles County Civil Grand Jury to conduct a management audit of MacLaren Children's Center. The purpose of the audit was to determine if improvements could be realized in three primary areas of the Center's operations: 1) human resource management particularly background checks for new and existing employees; 2) costs of operations; and, 3) efficiency of use of staff and other resources.

The audit scope included the following questions:

1) What are the Center's procedures and processes for recruitment and hiring including background checks?
2) Are adequate controls against hiring inappropriate individuals in place?
3) What are the Center's costs including cost per child per day, employee salaries, clothing costs, food and other costs?
4) Are adequate cost controls in place?
5) Is staff operating at optimal efficiency or are there duplications of effort?
6) What are the characteristics of the Center's population?
7) How is vocational training used?

AUDIT METHODS

Methods used for this audit included interviews with: the County's Chief Administrative Officer in his role as the head of the Interagency Children's Services Consortium; the facility's Interim Administrator; all of the managers and selected staff at MacLaren from DCFS, the Department of Mental Health, the Department of Health Services and the Los Angeles County Office of Education; and, managers and staff from the same agencies who play an administrative role regarding the staff and services provided by their agency at the facility. The facility was toured including the residential cottages, recreation areas, the on-site school and the health services facilities.

Budget and actual expenditure data for the current and past two fiscal years were collected and analyzed as were detailed organization charts and staffing rosters. Costs, staffing levels, staff mix and position allocations were assessed relative to services provided and the mission of the organization. It should be noted that because of the changes in organization structure at MacLaren, a consolidated budget does not yet exist for the facility. However, working with fiscal staff from each of the agencies, approximate budgets and expenditure records were assembled. Similarly, the

organization chart and staff assignments for the facility were in flux while the audit was underway and several iterations of these documents had to be prepared by the auditors to be able to accurately assess the deployment of staff.

Personnel and procurement procedures were reviewed and verified with administrative staff. Data on the MacLaren population was collected and analyzed for the current and last two fiscal years including age and sex distribution, admission and release data, academic achievement, mental health indicators and health status. To further analyze the population and length of stay data, more detailed data regarding average length of stay and number of admissions per child were collected for two randomly selected sample days from 2001 in addition to data collected on these subjects for the full year.

Audit field work was conducted between January and March, 2002. A copy of the draft report was provided to the Interim Administrator and an exit conference was held for comments and feedback before the report was finalized.

OTHER ISSUES

In accordance with Sections 7.45 and 7.46 of the U.S. General Accounting Office Government Auditing Standards, certain issues identified during an audit are worthy of being brought to the attention of management even though a specific finding was not included in the audit report. The issue of vocational training was raised by the Grand Jury and the following was found. In general, the program has been very limited in the past. However, a new expanded program is planned to begin in April 2002. An evaluation of this new program could not be conducted in the time frame of this audit but could be evaluated by a future Grand Jury or MacLaren management.

MacLaren currently does not have a formal vocational training program. MacLaren school administration reported that there have been problems in the past in trying to send children out of the facility for vocational training. Children sent out, they report, tend not to succeed for a variety of reasons, including being disoriented with the new environment and not being with other youths they know.

MacLaren does provide other independent living services, however, including classes and workshops co-sponsored by the Community College Foundation, such as:

- Job Search
- Mock Interviews
- Planned Parenthood
- Educational Goals
- Cleaning A House
- Dealing With Anger
- Meal Planning
- Cost To Live On Your Own

MacLaren Independent Learning Program staff provided the audit team with statistics regarding attendance at these classes, and they show that attendance per class ranges from 6 to 14 students.

MacLaren management reported that additional vocational training is planned for MacLaren, and in fact was scheduled to begin March 1, but got delayed, and is now scheduled for April 1.The planned vocational training is planned through the One-Stop centers, which would provide the training at MacLaren and would pay for it. According to documentation provided by MacLaren, One-Stop Centers "assist with job preparation, vocational assessment, interview techniques and other job training services." This program could be evaluated by future Grand Juries or the Department to measure its effectiveness.

2. Population Profile

- **The population at MacLaren Children's Center is increasingly older and psychologically and emotionally troubled. The majority of children are admitted from psychiatric hospitals, failed placements, juvenile hall or probation, or after running away from the facility. Many are medically fragile, some are developmentally disabled and school achievement of the population as a whole is well below grade level. There was an average of over six serious incident reports every day in 2001 such as children assaulting staff or each other.**

- **Average length of stay data show there are two groups in the population. The average length of stay for all children was 47.9 days based on all children at the facility on two sample days in 2001. But for the 86 percent of the population who stayed over 30 days, the average length of stay was 89.9 days. 193 children, or 63.7 percent of the 303 children in the sample, had been admitted more than once to MacLaren.**

- **Core staffing and the approach at MacLaren should be reconsidered given the profile of most of the population residing at the facility. The core staff working with the children now are Children's Social Workers and Group Supervisors. Children's Social Worker training is more geared to case management rather than direct mental health services. A mental health classification such as Licensed Psychiatric Technician would be more appropriate as the core staffing in the cottages who work with MacLaren's population. Reconfiguring core staffing by replacing most direct service Children's Social Workers and Group Supervisors with Licensed Psychiatric Technicians would also lower salary and benefits costs by an estimated $2.6 million per year.**

- **Approaches such as wraparound should continue to be monitored and expanded to the extent they are proven cost effective. Indications so far at MacLaren is that wraparound can help remove children from the ongoing cycle of stays at MacLaren.**

CENTER POPULATION

The average daily population for MacLaren Children's Center has been relatively stable at 144.3 for the two and one half years ending in December 2001. The stability of the population during this time period is demonstrated by separating this 30-month period into its three fiscal years. As shown in Exhibit 2.1, the average daily population was 144.6 for FY 1999-00, 141.9 for FY 2000-01 and 148.5 for the first six months of FY 2001-02.

Exhibit 2.1
Average Daily Population
MacLaren Children's Center
FY 1999-00 – FY 2001-02

	1999-00	2000-01	2001-02
July	133	160	153
August	133	146	159
September	134	135	156
October	132	135	142
November	153	125	134
December	137	130	147
January	128	128	-
February	145	147	-
March	142	146	-
April	158	145	-
May	171	151	-
June	169	155	-
Average	144.6	141.9	148.5
Average all months		144.3	

Source: "Daily Population for the Month"; Interagency Children's Services Consortium

In the past a capacity level was not explicitly stated at MacLaren. However, 124 was used as the unofficial capacity. According to the facility's Memorandum of Understanding (MOU), for any admission that pushed the population over 124, admission was not granted without the approval of the Department of Children and Family Services Director. When MacLaren became a licensed facility in August 2001, some remodeling took place and the California Community Care Licensing Division established the capacity at 156.

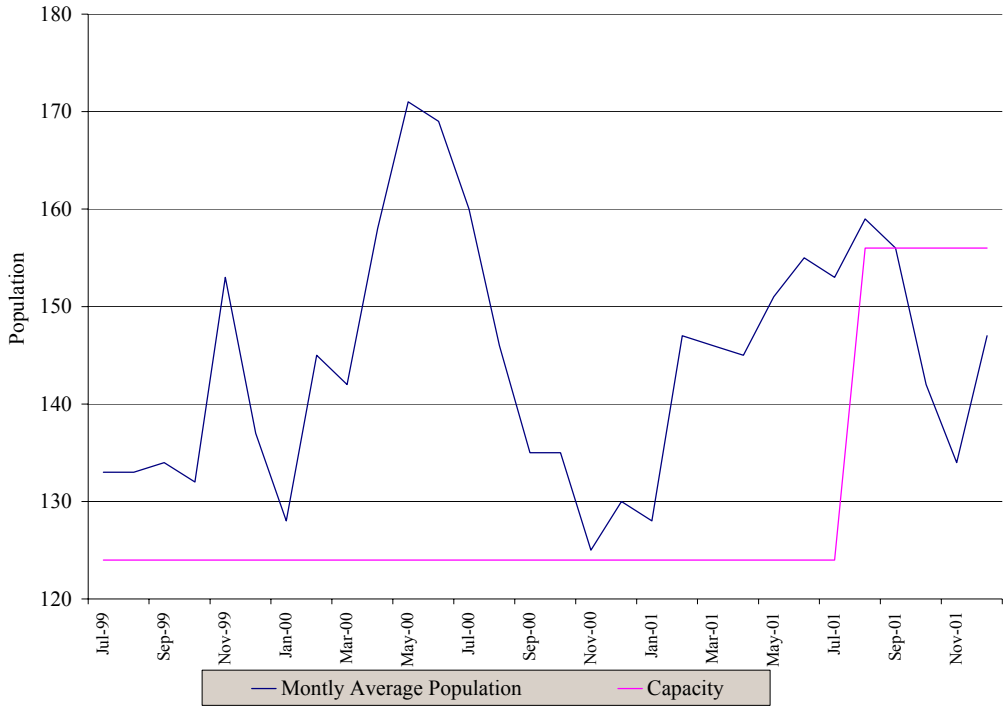
Exhibit 2.2 graphically depicts the average daily population figures for each month since July 1999 compared to facility capacity. The monthly average population exceeded 124 consistently since July 1999. However, there were days during the period when capacity was at or below 124.

Furthermore, even after the California Community Licensing Division increased the MacLaren capacity to 156, the Center still had days in August and September 2001 that were over capacity. In August, 18 days, or 58.1 percent of all days, were over capacity and 4 days, or 12.9 percent of all days, were at capacity. Therefore, MacLaren was at or exceeded its capacity of 156 a total of 71 percent of the time. The population improved slightly in September when 46.7 percent of all days were either at or over capacity.

From October through December 2001 MacLaren consistently remained under the capacity level of 156. While overcrowding seems to be reasonably under control, it

should be pointed out that the only way MacLaren can reduce its admissions is for DCFS to find alternative placements for the children. Reportedly, some success has been reached in this regard.

Exhibit 2.2
Monthly Average Population



Source: "Daily Population for the Month"; Interagency Children's Services Consortium

One of the apparent impacts of reducing overcrowding at MacLaren is that the remaining children are older and more troubled. The children for whom placements can be more readily found tend to be younger and less plagued with behavioral and other problems. So while the total number of children at MacLaren Children's Center has remained stable, and under capacity, teenagers, frequently a more difficult population under any circumstances, comprise an increasingly larger portion of the population.

The following data illustrate some significant trends in the composition of the MacLaren population. First, the number of children at MacLaren has increased in age over the past three fiscal years. As shown in Exhibit 2.3, children between the ages of 12 and 18 are the largest segment of the population at MacLaren. In Fiscal Year 1999-2000 the 12-18 age group composed 85.9 percent of the population at MacLaren. That number trended upward in the following two fiscal years to 86.9 percent in FY 2000-2001 and 89.2 percent in the first half of FY 2001-2002.

Exhibit 2.3
Age Composition of MacLaren Population

Age	FY 99-00	FY 00-01	FY 01-02
0 to 2	1.0%	1.3%	1.8%
3 to 4	0.9%	0.9%	0.6%
5 to 11	12.2%	10.9%	8.4%
12 to 15	52.9%	52.4%	51.3%
16 to 18	33.0%	34.5%	37.9%
Total	**100%**	**100%**	**100%**

Source: "Daily Admissions"; Interagency Children's Services Consortium

The data demonstrating the increased age of children is even more dramatic for children aged 16 to 18. This age segment, which represented 33.0 percent of the population in FY 1999-2000, increased to 34.5 percent in FY 2000-2001 and 37.9 percent in the first half of FY 2001-2002. Furthermore, the Shelter's admission data confirms the trend that the MCC population is increasing in age. In calendar year 1999, 429 children, or 29.9 percent of all admissions, were between the ages of 16 and 18. However, in calendar year 2001 that number increased to 643 children, or 36.9 percent of all admissions.

Perhaps equally as telling is the steady decrease in younger children at the Center. Facility data suggests that younger children as a percentage of overall MacLaren Children's Center population is declining. In Fiscal Year 1999-00 children aged 3 to 11 comprised 13.1 percent of the overall population. However, that population decreased to 11.8 percent in FY 00-01 and is down significantly in Fiscal Year 2001-2002 to 9.0 percent of the population. Moreover, the largest decline was in the 5 to 11 age group, where the loss in population has been the most pronounced, decreasing from 12.2 percent in FY 1999-00 to 8.4 percent in FY 2001-02.

The MacLaren population has been evenly divided by gender for the current and two previous fiscal years with males averaging 49.9 percent of the population and females 50.1 percent. During the two and one half year period reviewed, the racial/ethnic backgrounds of children at MacLaren has remained fairly constant with approximately half of the population black, and Hispanic and white children the second and third largest ethnic groups. Together, these three groups made up 95 percent of the population.

BACKGROUND OF MACLAREN'S POPULATION

Besides an older population, the majority of the population at MacLaren Children's Center can be characterized as having behavioral problems and emotional disturbances of varying degrees. Admission data for the last two and one half years, presented in Exhibit 2.4, show that 80.1 percent of admissions are from one of the following four sources (in order of magnitude):

1. failed placements (36.6%);
2. psychiatric hospitals (26.6%);

3. the County Probation Department/Juvenile Hall (10.2%); and,
4. readmission after running away from MacLaren (6.7%).

Only 18.5 percent of all admissions were admitted after being removed from their parents, legal guardians or relatives. The majority of admissions are children who have already experienced the trauma of being removed from their homes and have experienced further trauma or behavior/emotional problems associated with an unsuccessful placement, psychiatric hospitalization, being a runaway, or incarceration in Juvenile Hall.

As can be seen in Exhibit 2.4, the majority of releases from MacLaren, 48.2 percent, were to placements, primarily group homes but the majority of admissions, 36.6 percent were from placements that had failed. A high percentage, 20.8 percent were released to psychiatric hospitals, reflecting the mental health status of a significant portion of the population, and another 13.3 percent were "released" to runaway status.

Exhibit 2.4
MacLaren Children's Center Admissions and Releases
July 2000 – December 2001
By Origin of Admission and Point of Release

From/To:	Admissions	Releases	Admissions % Total	Releases % Total
Group Home	492	804	19.2%	31.3%
Foster Home	357	338	14.0%	13.2%
Foster Family Agency	86	96	3.4%	3.7%
Subtotal: Placements	*935*	*1,238*	*36.6%*	*48.2%*
Psychiatric Hospital	681	534	26.6%	20.8%
Parent, Legal Guardian, Relative	474	308	18.5%	12.0%
Probation/Juvenile Hall	261	129	10.2%	5.0%
Runaway (AWOL)	172	341	6.7%	13.3%
Out of State	18	5	0.7%	0.2%
Out of County	5	4	0.2%	0.2%
Medical Hospital	6	3	0.2%	0.1%
Street	2	-	0.1%	0.0%
Courtesy Hold	2	-	0.1%	0.0%
Misc.	2	4	0.1%	0.2%
Total Admissions	2,558	2,566	100.0%	100.0%

Source: Population Recap Monthly Reports; Interagency Children's Services Consortium

THE FAILED PLACEMENT PHENOMENON

As one indicator of the behavior and emotional problems associated with the MacLaren Children's Center population, failed placements are the primary source of admissions to the facility. A placement that has not worked out often means that the child was a behavior problem or somehow did not fit in to the facility.[1] Placement families and agencies such as group homes are not legally obligated to keep any child placed with them if the child is disrupting or posing a threat to the other children. A placement could also fail because the child asks to leave. In either case, a failed placement represents another destabilizing disruption in the life of a child who has already had major disruptions in their lives by being removed from their homes and who will probably need extra professional attention when they arrive at MacLaren.

As shown in Exhibit 2.4, admissions from group homes, foster homes and foster family agencies comprised 36.6 percent of all admissions during the 18-month period ending in December 2001. While a greater percentage of children were released from the facility to placements during that period than were admitted from failed placements, it is clear that a high percentage of placements do not work out. Some of these admissions are children who were previously admitted to MacLaren, then placed in a group home or other placement and then returned to MacLaren when the placement failed.

PSYCHIATRIC HOSPITAL ADMISSIONS AND RELEASES

At 26.6 percent, admissions from psychiatric hospitals were the largest percentage of admissions to MacLaren during the 18-month period ending December 2001. During the 18 month period reviewed, MacLaren Children's Center admitted 147 more children from a psychiatric hospital than were released to a psychiatric hospital. Additionally, the percentage of all admissions that come from a psychiatric hospital are 5.8 percent higher on average than the percent of all releases that go to a psychiatric hospital. Thus, the population of MacLaren that has spent time at a psychiatric hospital is increasing. The data does not distinguish admissions of children who were housed at Maclaren prior to their hospital stay as compared to new admittees. In either case, they represent a significant portion of the population that have high needs and impact other children and staff.

ADMISSIONS FROM PROBATION DEPARTMENT/JUVENILE HALL

For the most part, MacLaren cannot control how many children it admits, or where the children are admitted from. Exhibit 2.5 below shows the number of children whom MacLaren admitted from the Probation Department or Juvenile Hall. While the data indicate several peaks and valleys, such as the low numbers in the final months of 2000,

[1] Referencing the Cole Report McLaren management points out that placements fail the child, not the opposite, and that differently structured programs are needed for children with complex needs. We do not disagree but the high rate of admissions from failed placements still results in a greater proportion of the population at MacLaren having high needs.

the overall trend is that the number of admissions of children admitted from Probation or Juvenile Hall is on the rise.

Exhibit 2.5
Number of Admissions from Probation Department or Juvenile Hall

	Probation/ Juvenile Hall Admissions	Total Admissions	% Total
Jul-00	19	148	12.8%
Aug-00	13	142	9.2%
Sep-00	15	158	9.5%
Oct-00	11	140	7.9%
Nov-00	5	112	4.5%
Dec-00	8	114	7.0%
Jan-01	14	122	11.5%
Feb-01	15	149	10.1%
Mar-01	12	165	7.3%
Apr-01	22	153	14.4%
May-01	15	168	8.9%
Jun-01	10	133	7.5%
Jul-01	19	177	10.7%
Aug-01	23	169	13.6%
Sep-01	12	127	9.4%
Oct-01	24	153	15.7%
Nov-01	8	110	7.3%
Dec-01	11	118	9.3%
Total	**256**	**2558**	**10.0%**

Source: Population Recap Monthly Reports; Interagency Children's Services Consortium

Further examination of the MacLaren Children's Center admission and release data show two important trends, as presented in Exhibit 2.6. First, the number of admissions from Probation or Juvenile Hall compared to the number released to Probation has increased steadily over time. In FY 99-00, 61 more children were admitted into MacLaren from Probation or Juvenile Hall than were released. That number increased slightly in FY 00-01 to 67. However, in the first half of FY 01-02 that number swelled to 60 for only the first half of the fiscal year. On average, since July 2000, 14 children per month enter the MacLaren Children's Center from Juvenile Hall or after a release from the Probation Department.

For many of these children, charges against them have been dropped before admission to MacLaren and they are not classified as delinquent or taken under the authority of the Probation Department. However, their encounters with law enforcement reflect risky and possibly illegal behaviors. Adding children with these behaviors to the MacLaren environment contributes to the overall environment that affects all children at the facility.

Exhibit 2.6
Comparison of Probation/Juvenile Hall Admissions and Releases to Overall Admissions and Releases

	FY 99-00	FY 00-01	FY 01-02[2]
Probation/Juvenile Hall Admissions	115	159	97
Total Admissions	1750	1704	854
% Total	6.6%	9.3%	11.4%
Probation/Juvenile Hall Releases	54	92	37
Total Releases	1735	1705	861
% Total/Juvenile Hall	3.1%	5.4%	4.3%
Probation Admissions less Releases	**61**	**67**	**60**

Source: Population Recap Monthly Reports; Interagency Children's Services Consortium

The data illustrates that since July 1999, the Center saw a significant population gain from Probation/Juvenile Hall. Specifically, since July 1999, 188 children have been admitted into MacLaren from Juvenile Hall than have been released to Probation or Juvenile Hall.

RETURNING RUNAWAYS

The numbers of returning runaways at MacLaren represent a moderate segment of the population. The data indicates that the number of returning runaways at MacLaren ranges from a high of 14.4 percent in July 2001 to a low of 1.5 percent in December 2000. Overall, since July 1999, the monthly average of returning runaway admissions was 6.7 percent. Furthermore, the number of runaway releases at MacLaren is much higher than the number of runaways admitted into the Center. Since July 2000 the percentage of all admissions that come from runaways are 6.6 percent lower on average than the percent of all runaway releases. In that time period, there have been 169 more runaway releases than admissions from runaways.

The Center is not a secured institution, and staff may not restrain children from leaving. Children can come and go from the Shelter, as often and whenever they want. Exhibit 2.7 below shows the number of runaway incidents by fiscal year and age group.

[2] As of 12/31/01.

Exhibit 2.7
Number of Runaway Incidents*

Age	FY 1999-00	FY 2000-01	FY 2001-02**	Total
0 to 5	0	0	0	**0**
5 to 11	1	0	1	**2**
12 to 15	92	86	61	**239**
16 to 18	131	115	68	**324**
Total	**224**	**201**	**130**	**565**

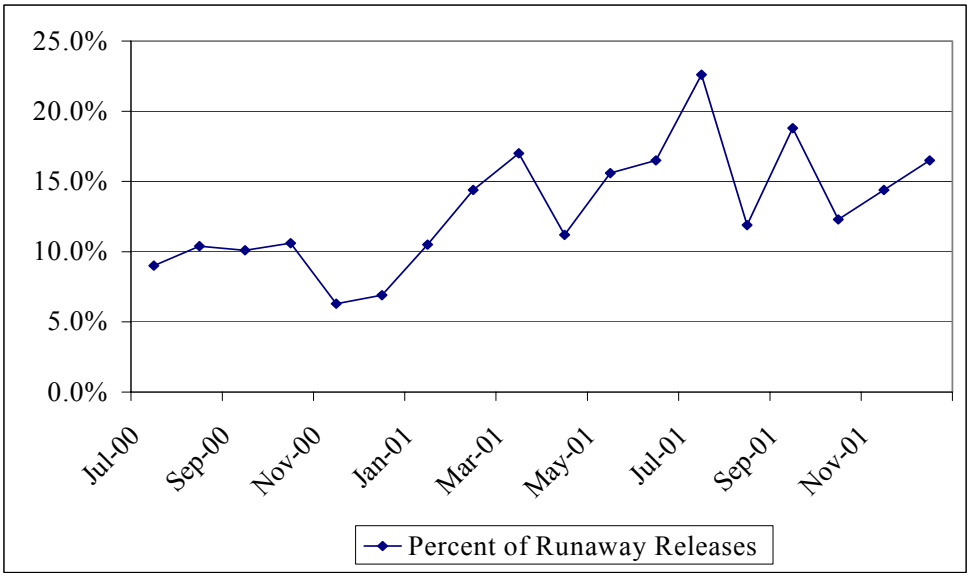
Source: Population Recap Monthly Reports; Interagency Children's Services Consortium

* Note: An "incident" is not the same as a child. An individual child may run away several times and therefore contribute several incidents to the total count.

** Data for first half of FY 2001-02 only

The Center's release data show one important trend. The number of runaway incident at the MacLaren Children's Center has been steadily increasing over time. Exhibit 2.8 below shows the number of runaway releases compared to all releases at MacLaren Children's Center. In Fiscal Year 2000-2001, on average, only 8.9 percent of all releases were because of runaways. However, in Fiscal Year 2001-2002 that number has increased to 15.1 percent. This evidence suggests that this steady increase of runaway incidents will continue.

Exhibit 2.8
Percent of Runaway Releases



Source: Population Recap Monthly Reports; Interagency Children's Services Consortium

AVERAGE LENGTH OF STAY

An evaluation of MacLaren Children's Center conducted for the County in 1998 reported that a key problem with the facility was the expectation that it would play two irreconcilable roles; that of an emergency shelter and that of a treatment facility. The report recommended that the County agencies responsible for the children at MacLaren jointly create an Emergency Shelter Care and Long Term Intensive Care System, of which the MacLaren Children's Center would serve primarily as a shelter care facility and not a group home. The report recommended that MacLaren should be only one component of an expanded County-wide protection and stabilization system.

A follow up to the 1998 assessment reported that MacLaren had redefined its mission to emphasize its role as a temporary facility assisting children in transition to family and community living. The report goes on to say that this new mission had not been fulfilled, however, because of the continued absence of community based service providers to provide long term care.

In addition to collecting average daily population data for the last three years, detailed data were collected for two selected days in 2001 to further analyze the MacLaren population. For these two representative days, March 1 and September 1, 2001, the average length of stay and number of admissions for every child at the facility was collected. A review of this data revealed that a significant number of children continue to reside at MacLaren for extended periods of time with many admitted more than one time. In short, the same problems found in the 1998 assessment and again in the 2001 follow up analysis continue to be true. MacLaren managers indicate that they do not believe this situation has significantly changed as of the writing of this report due to a lack of placement alternatives for many of the children at MacLaren.

MacLaren's Operational Agreement establishes a goal of transitioning children out of the facility to a community or family setting within 30 days. In our sample the average length of stay for all children was 47.9 days. However, as shown below in Exhibit 2.9, the average length of stay increases to 89.9 days for lengths of stay longer than 30 days. For stays under 30 days, the average length of stay was 11.6 days.

Exhibit 2.9
Average Length of Stay at MacLaren

	Days
Average Length of Stay	47.9
Average Length of Stay Over 30 Days	89.9
Average Length of Stay Under 30 Days	11.6
n=303	

Source: Special Report prepared by MacLaren Children's Center staff

As shown in Exhibit 2.10, the average length of stay is much longer for the male population than the female population. Based on our sample, we found that the length of stay is over 24 days longer for the male population than that of the female population. On March 1, 2001 the length of stay was 30 days longer on average for males than females.

Exhibit 2.10
Length of Stay at MacLaren

	03/01/01	9/1/01	**Total**
Male	64.3	60.9	**62.6**
Female	34.4	45.3	**38.3**
Total	**44.5**	**52.4**	

Source: Special Report prepared by MacLaren Children's Center staff

As shown in Exhibit 2.11, of the total number of children in our sample, 86.1 percent or 261 children, had a length of stay over 30 days. Of the 261 children, 125 children, or 41.3 percent, had multiple visits at MacLaren longer than 30 days. Moreover, including repeat admissions in the sample 469 visits were longer than 30 days.

Exhibit 2.11
Length of Stay for All MacLaren Residents
Two Days in 2001

Length of Stay	**Number of Children with One Stay**	**Percent**
More than 30 Days	261	86.1%
Less than 30 Days	42	13.9%
Total	303	100%

Source: Special Report prepared by MacLaren Children's Center staff

With 86.1 percent of the population in the sample staying longer than 30 days, the data demonstrates that a large segment of the MacLaren population can be classified as "Long Term" as this sub-population's average length of stay was 89.9 days[3]. The characteristics of this population are that they generally stay at the facility longer, are likely to have been at the Shelter before, and are likely to return. This population is at the facility for many reasons, but primarily because of failed placements.

The duration of the lengths of stay at MacLaren become more troubling when factored in with repeat admissions. There is significant increase in the overall length of stay when repeat admissions are included. One child, present at the facility both days of the sample,

[3] The auditors defined "Long Term" as any consecutive stay longer than 30 days, which is the official MacLaren goal for each child's length of stay, as codified in the Operational Agreement. MacLaren representatives point out that transitional shelter regulations allow for stays of up to 90 days. However, stays of 90 days are inconsistent with MacLaren's program goals and approach.

had been in residence at MacLaren for 728 days over a three-year period. As shown in Exhibit 2.12, which includes repeat admissions, 270 children had an overall length of stay at MacLaren longer than 30 days. Of that number, 12 children had a length of stay over 400 days including repeat admissions. Moreover, by factoring in repeat admissions, 89.1 percent of the children in our sample had an overall combined length of stay of over 30 days. The average was 160 days or more than five full months.

Exhibit 2.12
Frequency of Length of Stays at MacLaren
All Admissions

Length of Stay (days)	1999 – 2001
700+	2
600-700	2
500-600	4
400-500	4
300-400	27
200-300	55
100-200	79
30-100	97
Total	**270**

Source: Special Report prepared by MacLaren Children's Center staff

Based on our sample, after the first admission, children have an average of 2.3 additional admissions into MacLaren. Out of a total population of 303, 193 children, or 63.7 percent, had more than one admission to MacLaren. Furthermore, as shown in Exhibit 2.13, after the first admission, 35.3 percent of the children had one or two additional admissions into MacLaren. However, 16 children had 10 or more admissions into MacLaren after their first admission into MacLaren.

Exhibit 2.13
Number of Repeat Admissions by Number of Children

Number of Repeat Admissions	Number of Children	Percent
10+	16	5.3%
9	4	1.3%
8	5	1.7%
7	3	1.0%
6	8	2.6%
5	9	3.0%
4	17	5.6%
3	24	7.9%
2	43	14.2%
1	64	21.1%
0	110	36.3%
	303	**100.0%**

Source: Special Report prepared by MacLaren Children's Center staff

Additionally, of the 16 children with more than 10 re-admissions into MacLaren, many are well in excess of 10 re-admissions. In our sample we found 4 children with 17 re-admissions, for a total of 18 admissions into MacLaren over a two or three year period. One child had 19 re-admissions after their initial admission to the Center.

INCIDENT REPORTS

Another indicator of the behavioral problems associated with the MacLaren population is the number of incidents reported. Incidents include allegations of child abuse at the facility, assaults and attempted assaults on children and staff by other children and staff. Reports of such incidents averaged 6.4 per day in calendar year 2001 as shown in Exhibit 2.14. As can be seen, most of the reports concern assaults and attempted assaults on staff by residents. Assaults on residents by other residents also comprise a significant portion of the reported incidents.

Exhibit 2.14
Serious Incident Reports at MacLaren Children's Center

	1999	2000	2001
Allegation of Child Abuse (Staff against Resident)	22	35	53
Assault on Child (Resident against Resident)	446	717	575
Attempted Assault on Child (Resident against Resident)	101	286	271
Assault on Staff (Resident against Staff)	445	672	796
Attempted Assault on Staff (Resident against Staff)	306	614	634
Total	1,320	2,324	2,329
Average per Day	3.6	6.4	6.4

Source: Special Report prepared by MacLaren Children's Center staff

The date in Exhibit 2.14 indicates that the numbers of incident reports are increasing only for assaults and attempted assaults on staff by residents. This suggests that the residents of MacLaren are more likely to be aggressive and violent toward staff as they get older.

SCHOOL ACHIEVEMENT

Under the auspices of the Los Angeles County Office of Education (LACOE), the MacLaren Children's Center offers education to nearly every child at MacLaren. With a population generally in transition and changing, it is very difficult for the children to become acquainted and familiar with the school at MacLaren.

According to data provided by LACOE, 70 percent of all children enrolled at the MacLaren Children's Center School perform below their academic grade level. Furthermore, as the data indicates in Exhibit 2.15, the grade level performance of the students at the MacLaren Children's Center School is well below average.

Exhibit 2.15
2000-2001 Math and Reading Grade Level
at MacLaren Children's Center School

Grade	Male Reading	Male Math	Female Reading	Female Math
12th	6.0	5.3	4.7	4.3
11th	4.9	4.5	5.5	5.0
10th	5.3	4.3	5.1	4.4
9th	4.1	4.0	3.9	3.7
8th	3.1	3.8	3.3	3.4
7th	2.1	2.3	2.5	3.5
6th	2.1	2.5	3.2	3.3
5th	1.6	1.8	2.6	2.5
4th	2.1	2.0	1.8	1.5
3rd	0.0	0.0	0.0	0.0
2nd	0.0	0.0	0.0	0.0
1st	0.0	0.0	0.0	0.0

Source: MacLaren School report; Los Angeles County Office of Education

Generally, as stated earlier in this report, MacLaren children are a high need and often maltreated population. Thus, these children often perform significantly poorer on standardized tests and overall academic performance.

However, the problem of poor academic achievement is compounded at the Center, by a significant percentage of the population not attending school on a regular basis. As shown in Exhibit 2.16, the number of children not attending school varied significantly during Fiscal Year 2000-2001. However, on average, 12.7 percent of residents at MacLaren did not attend school during Fiscal Year 2000-01. Children not attending are explained by LACOE staff as mostly being at court, being ill, or simply refusing to attend school.

Exhibit 2.16
MacLaren Children's Center Attending School

	School Enrollment*	Average MacLaren Population*	Residents Not Attending School	Percent Not Attending School
Jul-00	125	160	35	21.9%
Aug-00	125	146	21	14.4%
Sep-00	127	135	8	5.9%
Oct-00	125	135	10	7.4%
Nov-00	100	125	25	20.0%
Dec-00	90	130	40	30.8%
Jan-01	122	128	6	4.7%
Feb-01	126	147	21	14.3%
Mar-01	146	146	0	0.0%
Apr-01	133	145	12	8.3%
May-01	142	151	9	6.0%
Jun-01	125	155	30	19.4%
Total	**1486**	**1703**	**217**	**12.7%**

Source: MacLaren School report; Los Angeles County Office of Education
Population: "Daily Population for the Month", Interagency Children's Services Consortium

* Note: School enrollment based on average daily attendance. Average MacLaren population based on MacLaren population reports. Residents not attending school would vary on a day by day basis from number shown in table since that is based on averages.

MEDICALLY FRAGILE POPULATION

Currently, the Department of Health Services (DHS) keeps data on the number of children at MacLaren that the Department classifies as medically fragile. The data, as presented in Exhibit 2.17 below, show that for calendar year 2001, there is an upward trend in the percentage of the population at MacLaren that is considered medically fragile. In the first three months for which data is available, the number of medically fragile children ranged between 14.3 percent and 24.5 percent of the total population. However, starting in June 2001 MacLaren saw a prominent increase in reports of medically fragile children. The increase reached its pinnacle in October 2001 when almost 50% of the average population at MacLaren were classified medically fragile.

Medically fragile is defined by DHS as those with medical conditions requiring specialized in-home health care with dependency on specialized equipment, specialized procedures, or special medication regimens.

Exhibit 2.17
Number of Medically Fragile Children at MacLaren
Calendar Year 2001

Month	Avg. Daily Population	Number of Children Medically Fragile	Percent
Jan-01	128	N/A	N/A
Feb-01	147	21	14.3%
Mar-01	146	33	22.6%
Apr-01	145	N/A	N/A
May-01	151	37	24.5%
Jun-01	155	65	41.9%
Jul-01	153	56	36.6%
Aug-01	159	49	30.8%
Sep-01	156	55	35.3%
Oct-01	142	67	47.2%
Nov-01	134	51	38.1%
Dec-01	147	49	33.3%
Average	147	48.3	32.9%

Source: MacLaren Children's Center Fragile List; LAC+USC Hospital

On average, an estimated one third of the average daily population, or 32.9 percent, were classified medically fragile in Calendar Year 2001. This poses significant problems for the staff of DHS. Many of the ailments range from asthma (by far the most common ailment) to more serious diseases such as AIDS. Additionally, many of diagnoses are more mental conditions, such as mental retardation and autism.

STAFFING AND APPROACH AT MACLAREN CHILDREN'S CENTER

Core staffing at MacLaren is comprised of 135 budgeted Children's Social Workers and 47 budgeted Group Supervisors. It is these staff positions that provide most of the direct services to the residents such as supervision in the cottages and one-on-one individual supervision. Children's Social Worker is the core classification at the Department of Children and Family Services, which MacLaren was a part of until the Interagency Children's Services Consortium was created.

The County's job description for Children's Social Worker describes the essential job functions as,

> "…supervision and placement of minors in need of protective services due to physical and/or sexual abuse, neglect or exploitation….Incumbents must possess a knowledge of…resources and casework techniques to resolve child welfare problems"

Minimum requirements include experience providing casework services to children or families.

The County's job description for Psychiatric Technicians describes the essential job functions as:

> "Provides mental health services to mentally disordered patients as a member of a Psychiatric emergency team, crisis intervention team, or therapeutic team…"

Minimum requirements are experience assisting mental health professionals in the delivery of preventive therapeutic and rehabilitative psychiatric services to emotionally disturbed or mentally deficient patients. While a social work background may have been appropriate in the past, the nature of much of the population at MacLaren now requires a classification with a stronger mental health background.

The Director of the Mental Health division has proposed a new mix of staffing in the cottages that would be a mix of existing Children's Social Workers, Group Supervisors and mental health staff including Psychiatric Technicians. This proposal is suggested to address the significant portion of the population in crisis at MacLaren.

This proposal makes sense given the profile of the population. However, it is not clear why all the Children's Social Worker classifications should also remain other than because they have always been there. A stronger mental health orientation would be appropriate for the population and should result in more effective services if combined with an appropriate therapeutic model. Costs should also be lowered as Psychiatric Technicians are not paid as highly as Children's Social Workers or Group Supervisors. They would need to be supervised by higher paid mental health workers but a mix of cottage staff comprised primarily of Psychiatric Technicians would result in lower costs.

By replacing all but 20 percent of the budgeted Children's Social Workers and Group Supervisors with Psychiatric Technicians, salary costs could be reduced as follows.

Exhibit 2.18
Salary Cost Differences
Between Children's Social Workers, Group Supervisors
and Psychiatric Technicians

Classification	Annual Salary	Number Budgeted	Annual Cost	Number Retained	Annual Cost	Savings/ (Cost)
Children's Social Worker III	$57,840	135	$7,808,400	27	$1,561,680	$6,246,720
Group Supervisor II	46,408	47	2,181,176	9	417,672	1,763,504
Psychiatric Technician III	40,644	-	-	146	5,934,024	(5,934,024)
Total		182	$9,989,576	182	$7,913,376	$2,076,200

Source: MacLaren salary and position report

At a rate of approximately 25.8 percent, benefits costs would be reduced by approximately $535,660, resulting in total cost reductions of approximately $2.6 million. Additional savings could potentially be realized if the new staffing in the cottages

reduced the need for as many Psychiatric Social Workers and Clinical Psychologists as currently assigned to the facility.

Other approaches such as the wraparound program appear to be proving effective at breaking the cycle of repeated placement failures and returns to MacLaren. This program and others like it should continue to be monitored and reported on to the Interagency Children's Services Consortium to verify their cost-effectiveness before further expansion. Evaluations conducted by MacLaren in 2000 and 1999 were reviewed and both showed positive results in a number of key areas including school attendance and achievement, behavior and others.[4]

CONCLUSION

As the number of children at the Center has grown older and the number of children needing additional and special services has escalated, staff at MacLaren is faced with many difficult decisions regarding the child's best interest. The Center handles a very troubled and difficult population that is getting older and is of very high need. A stronger mental health component to the core staffing at MacLaren is appropriate at this time. A proposal prepared by the Mental Health division to reconfigure cottage staffing to add more mental health professionals is a logical proposal for dealing with the population. A more comprehensive replacement of Children's Social Workers and Group Supervisors with mental health staff is a preferred approach however because it would allow for introduction of a new more therapeutic approach to residential services and it could be done at lower cost.

RECOMMENDATIONS

Based on the above findings, it is recommended that Interagency Children's Services Consortium:

2.1 Request that the Director of Mental Health services at MacLaren prepare a proposal for a program to replace Children's Social Workers and Group Supervisors with mental health staff in the cottages to provide a more therapeutic approach appropriate to much of the population at MacLaren; (Recommendation 104)

2.2 Request that the Director of Mental Health services prepare measures of effectiveness or outcomes for review and approval by the Consortium to use in measuring the results of the proposed program; (Recommendation 105)

2.3 After review and approval of the proposal, implement on a pilot basis and measure results to ensure that desired results are achieved or, if not, determine what changes are needed; (Recommendation 106)

[4] Note: "The 10 Child Project" Wraparound Evaluation, August 1999 and July 2000.

2.4 Replicate the program throughout the facility once its effectiveness has been established; and, (Recommendation 107)

2.5 Collect evidence to verify the effectiveness of programs such as Wraparound and expand to the extent possible. (Recommendation 108)

COSTS AND BENEFITS

The benefits of the recommendations above would include a more appropriate mix of staff and approach to dealing with the population as profiled in this report section. Costs would also be lowered as the Psychiatric Technician classification is not paid as highly as Children's Social Workers or Group Supervisors. Assuming 20 percent of the budgeted Children's Social Workers and Group Supervisors were retained and 80 percent replaced with Psychiatric Technicians, salary and benefits costs would be reduced by approximately $2.6 million annually.

3. Criminal Background Checks at MacLaren

- **In August 2001 MacLaren Children's Center became a State licensed facility and subject to California Department of Social Services licensing requirements, including conduct of criminal background checks of all employees working at the facility who have contact with children. The background check includes statewide and national criminal records checks as well as a determination of whether the applicant's name appears on the Child Abuse Central Index.**

- **In June 2001, in preparation for licensure, MacLaren management began the process of conducting background checks of all employees at the facility. Through this process, MacLaren discovered that 17 employees had previously undisclosed criminal histories considered unacceptable either by CDSS or by a stricter set of standards established by MacLaren management. In addition, four individuals voluntarily resigned or transferred during the background checks process.**

- **The newly instituted background checks process appears to be working well for most existing and new MacLaren employees assigned from the Departments of Children and Family Services, Mental Health and Health Services. Of 63 randomly selected employees, clean results were found for 51. For the majority of the remaining 12 employees there were reasonable explanations as to the reason clean results were not documented. No background check documentation was found for Resource Utilization Management unit staff or some contractors who have contact with children.**

- **The separately administered background check process for Los Angeles County Office of Education (LACOE) employees at the on-site school does not appear to be working as well. Of 30 LACOE employees selected, background checks could be verified for only 10, one of which contained a criminal history with no details available. LACOE was not able to provide background check documentation for any of their contractors working on site. LACOE reports that it has been administering its background check procedures under a different set of regulations than MacLaren and reports that is was not made aware of the new background check policies and procedures implemented at MacLaren until this audit.**

BACKGROUND

In December 2000 a lawsuit filed against the State of California by the nonprofit, San Francisco-based Youth Law Center charged that the State was not enforcing standards of care and exposing thousands of children to overcrowded and dangerous shelters. This lawsuit resulted in a court order in April 2001for all state shelters housing foster children to become licensed. In mid-2001, the Los Angeles County Board of Supervisors voted to comply with the court order to obtain a state license for MacLaren Children's Center to operate as a Community Care Facility for children in the County. A provisional state license was granted in August 2001, which is valid for one year, and must be renewed in August 2002.

State licensure is administered by the California Department of Social Services (CDSS) through its Community Care Licensing Division (CCL). Facilities licensed by CCL are called Community Care Facilities. In its guidance to Community Care Facilities, CDSS requires that "all applicants, licensees, residents, and employees of community care facilities who have contact with clients" undergo background checks. The process of these background checks includes manual fingerprinting or the use of the electronic Livescan system. CDSS transmits this information to the California Department of Justice (DOJ) and the Federal Bureau of Investigations (FBI) who conduct State and national criminal records background checks. DOJ notifies CDSS of the results of the state and national checks, including whether the applicant's name was found in the Child Abuse Central Index. CDSS then notifies the facility as to whether the applicant has a criminal history. If the criminal record is conviction of a felony, then the individual is excluded from returning to the facility, unless an exemption is granted. Many crimes are not eligible for exemption by CDSS standards; however, exemptions may be granted under the state's system in some circumstances.

Crimes that may qualify for exemption include:

- Murder/Voluntary Manslaughter[1]
- Conviction for attempt to assault with intent to commit mayhem
- Prior to 1/1/65 conviction of willfully causing or permitting any child to suffer under circumstances or conditions likely to produce great bodily harm or death
- Any felony punishable by death or imprisonment in the state prison for life but not for an indeterminate sentence.[1]
- Enhancement for any felony which inflicts great bodily harm.

According to CDSS guidelines, the applicant must submit the following information to receive an exemption:

- A written description of the crime(s)
- A description of how the individual's life has changed to avoid criminal activities
- Certificates or other documentation of training, education or rehabilitation, if completed
- Three current letters of character reference (not from family members or facility employees)
- Evidence of counseling or therapy, if any

In response to a direct inquiry, CDSS indicated that the State background check process can take anywhere from three days to three months, "depending on the type of criminal record information involved." National FBI background checks could take anywhere from seven days to three months, with the average being about 47 days.

[1] The CDSS regulations state that "Exemption may be granted for murder or voluntary manslaughter if [applicant] is rehabilitated pursuant to Health & Safety Code Section 1522(g)(1)… and Penal Code Section 4852.01, 4852.03 and 4852.05." The exemption for "any felony punishable by death or imprisonment" also is granted if applicant is rehabilitated pursuant to Health & Safety Code Section 1522(g)(1).

CDSS also transmitted information to the auditors indicating that the State has a process of notifying employers regarding subsequent arrests within California of employees who have had background checks, and that notification takes place immediately after DOJ receives information from reporting agencies. There is no process of notification of subsequent arrests at the national level.

In preparation for state licensure, MacLaren Children's Center began conducting background checks on all of its existing employees in June 2001[2]. As a result of this process, the facility discovered that 17 employees had previously undisclosed criminal histories considered unacceptable either by CDSS or by a stricter set of standards established by the newly appointed interim administration[3]. In addition, four individuals voluntarily resigned their positions during the background checks process. Those employees whose criminal histories were not accepted at MacLaren generally were transferred back to the originating departments, (i.e., the Departments of Children and Family Services, Mental Health, or Health Services).

Exhibit 3.1 illustrates activities to date related to individuals who were not allowed to return to MacLaren or who voluntarily resigned or transferred during the process.

Exhibit 3.1

Results of MacLaren Background Checks of Existing Employees Who Were Not Allowed to Return to Facility

	Criminal Record	Action Taken
1	Felony DUI	Transferred to another department
2	Driving while under the influence; did not disclose on employment application	Transferred to another department
3	Misdemeanor petty theft; did not disclose on employment application	Transferred to another department
4	Disturbing the peace	Transferred to another department
5	Misdemeanor driving w/ suspended license; did not disclose on employment application; was on employment probation	Released from probation and thus from County employment

[2] Prior to this, staff assigned to MacLaren followed their respective Department's policies regarding background checks. These policies differed from department to department. Therefore there were inconsistencies as to the type and degree of background checks conducted on employees.

[3] We were told that the stricter standards established by MacLaren interim administrators are designed to ensure that only the most qualified candidates are allowed to work and have contact with the children at MacLaren.

	Criminal Record	Action Taken
6	Burglary	Not allowed to return to facility
7	Misdemeanor driving while under the influence; provided false information to police; domestic violence	Transferred to another department
8	Misdemeanor petty theft—did not disclose on employment application	Transferred to another department
9	Felony bookmaking	Transferred to another department
10	Driving while under the influence	Transferred to another department
11	Embezzlement, forgery, theft	Employee resigned
12	Misdemeanor non-sufficient funds—checking	Not allowed to return to facility
13	Robbery/receiving stolen property; trespassing with intent to interfere or injure	Transferred to another department
14	Disturbing the peace	Employee resigned
15	Possession of controlled substance	Transferred to another department
16	Petty theft; stolen credit card	Not allowed to return to the facility
17	Possession of controlled substance; loaded firearm	Not allowed to return to the facility
18	Trafficking controlled substance	Not allowed to return to the facility
19	Possession of narcotics; driving while under the influence; did not disclose on employment application	Transferred to another department
20	Questionable Livescan results; was scheduled to be re-Livescanned	Transferred to another department
21	Questionable Livescan; was scheduled to be re-Livescanned	Transferred to another department

Source: MacLaren Children's Center Personnel Office documents

According to the MacLaren Children's Center Interim Personnel Officer, in addition to the above individuals, who will not be returning to MacLaren, 11 individuals were found to have criminal records but were granted exemptions by the facility, and therefore allowed to continue their employment there. Of those who were granted exemptions:

- Three had expunged criminal records
- Two were arrested only, but not convicted
- Three had records of minor welfare fraud
- Two had driving while under the influence records
- One had a petty theft record, which was disclosed at the time of application

Also, 11 other individuals are in a "pending" status, because the results of the Livescans have been delayed. Once the results for these individuals are in, the facility will make decisions using the criteria described above to determine whether they will be allowed to continue work at MacLaren

As mentioned above, the interim MacLaren management developed a set of standards designed to ensure that only the most qualified candidates be allowed to work at the facility and have contact with the children there. According to these standards, examples of histories that may be deemed unacceptable at MacLaren include the following:

- Conviction within preceding five years
- Any felony conviction
- Conviction/arrest involving violence, aggression, force, or moral turpitude
- Conviction/arrest involving children
- Conviction/arrest involving use/possession/sale of illegal substances

In determining whether to remove the individual from MacLaren, the Administrator may use one or more of the following considerations:

- Whether the crime is non-exemptible based on CDSS guidelines
- The nature of the offense
- Period of time since the crime and number of offenses
- Circumstances surrounding the commission of the crime/offense (e.g., age, demonstration of poor judgment, use of force, injury, use of a weapon, etc.)
- Rehabilitation, or
- Honesty and truthfulness

These guidelines have not yet been documented in the official MacLaren policies, and they will need to be in order to ensure their continued and effective use.

HOW THE BACKGROUND CHECK PROCESS WORKS NOW

As mentioned above, the state licensure process resulted in a new set of procedures for conducting background checks of MacLaren employees. The Interim Personnel Officer at MacLaren and human resources representatives at the Departments of Mental Health and Health Services, (DMH and DHS) report that in addition to the background checks that were done on existing employees, new employees hired to work at MacLaren must now undergo a background check and the results must be received by the MacLaren Personnel Officer prior to their commencing employment. Records of the background checks process are now centralized at MacLaren for all employees and contractors except Los Angeles County Office of Education employees assigned to MacLaren.

Department representatives report that the recruitment and hiring processes for DCFS, DMH and DHS employees applying to work at MacLaren is a joint effort between MacLaren and these respective departments. In most cases, MacLaren, DCFS, DMH and DHS human resources staff conduct the initial notifications, testing and screening of applicants, and existing MacLaren managers interview and decide on the final hiring of these staff. There are some exceptions to this with respect to DHS staff, in which case DHS staff at Los Angeles County + University of Southern California Hospital (LAC+USC) have had the primary role in the interviewing and hiring process, in particular with respect to the lead Physician and Nurse Manager.

Once the decision to hire is made, then MacLaren, DCFS, DMH and DHS staff process the administrative County forms, while a background check is conducted for staff from these three departments by the MacLaren personnel office. New hires are not brought on board until the clean results are provided or an exemption has been obtained from CDSS and MacLaren.

The process for LACOE staff is different. For this group--which includes teachers, administrators and support personnel at the on-site school--the entire recruitment, hiring and background checks process is conducted by LACOE staff. The MacLaren manager responsible for licensing reports that a background check waiver was granted to LACOE because CDSS reviewed LACOE's process and found it to be similar to that required by CDSS; however, no documentation to this effect has been provided by MacLaren staff. Human Resources representatives at LACOE report that since 1997, all teachers, administrators and support personnel must undergo a background check before being hired. A review of LACOE policies and procedures indicates that State and national searches are supposed to be conducted on these applicants.

REVIEW OF BACKGROUND CHECKS OF SAMPLE OF EMPLOYEES

As part of this audit random verification of the background checks process was conducted for approximately 15 percent of all employees and contractors at MacLaren. This review required a visit to the LACOE Human Resources office, where background checks documentation is kept for all LACOE employees, including those assigned to MacLaren. The review, which also included a sample of newly hired employees, showed the following:

- The process for existing and new employees assigned to MacLaren from DCFS, DMH and DHS appears to generally be working well. Of 63 randomly selected employees, clean results of background checks were found for 51 employees. The majority of the remaining 12 employees had reasonable explanations of why the results were not verifiable, as indicated below:
    - Two were new employees and background checks were pending
    - Four were on extended leaves of absence
    - Two were no longer assigned to MacLaren
    - The remaining four should have had background checks. Three of the four are from the Resource Utilization Management Unit, which, as discussed below, did not undergo background checks, and should have.
- Contractor employee files also generally contained the required documentation regarding background checks, with some key exceptions: landscaping staff and some DHS contractors who have direct contact with children had not undergone background checks. Of 32 contractor names randomly selected, we were able to verify clean results for only 19 employees. Of the remaining 13:
    - Three did not have any contact with children or performed their work off-site
    - Livescans had been completed but results were delayed in two cases
    - One person had very recently been Livescanned, and results were not in yet
    - The results for one contractor employee could not be verified
    - Four landscaping contractor employees had not been fingerprinted
    - One DHS contract dentist and one DHS contract lab worker had not been fingerprinted
- The results of background checks conducted for the majority of LACOE employees could not be verified. Of 30 employee files reviewed, background checks could be verified in only ten cases. One file contained a criminal history, but no details were available in the file. In addition, LACOE staff were unable to provide any information regarding its contractors assigned at MacLaren, despite repeated requests for this information. Also, a review of the criteria used to disqualify employment candidates of MacLaren and candidates of LACOE showed differences, with the new MacLaren guidelines being more stringent.

  LACOE staff provided this audit team with documentation showing that they had undergone an audit by the California Department of Justice in May 2000 that found that LACOE Criminal Offender Record Information (CORI) was stored in personnel files, in violation of California law. They also provided documentation showing that DOJ regulations require that CORI information "be destroyed after employment determination has been made…" This, they say, is the reason our audit team was unable to verify the criminal background checks of 20 out of 30 employees.

However, it has been reported that prior to 1997, LACOE did not have a policy of conducting background checks on all employees, and several of the employees assigned to MacLaren were hired prior to this date. Additionally, MacLaren record-keeping practices were entirely different than LACOE's, and we were able to verify that other MacLaren employees from all other departments had undergone background checks. LACOE management reports that they were never informed of MacLaren's new background check policies and procedures until this audit. Also, the record-keeping practices at LACOE were inconsistent, as we did find evidence of criminal background checks in some cases.

- Employees from the Resource Utilization Management Unit (a DCFS unit), who are housed at MacLaren and do have contact with the children at MacLaren, did not undergo background checks.
- Policies and procedures related to background checks at MacLaren have not been fully documented, and currently are working based on verbal understandings among the departments who have staff assigned at MacLaren.

CONCLUSION

In general, the MacLaren administration has done a good job of bringing the facility into compliance with CDSS requirements to conduct background checks on new and existing employees. There are exceptions, however, and these include background checks conducted by LACOE, which are conducted in a different manner than those conducted by MacLaren, resulting in our inability to confirm that background checks were in fact conducted on staff assigned at MacLaren and that clean criminal records were obtained. Other exceptions include the Resource Utilization Management unit staff at MacLaren and some contractors, who do have access to children in the facility, but who did not undergo background checks.

RECOMMENDATIONS

It is recommended that MacLaren Children's Center:

3.1 Immediately bring all staff and contractors assigned to the facility who have or could have contact with children there in compliance with CDSS and MacLaren policies regarding background checks; (Recommendation 109)

3.2 Seek an agreement with LACOE regarding the background checks of employees assigned to the MacLaren School, in which LACOE agrees to provide MacLaren with legally certified documentation regarding the results of background checks conducted of LACOE staff. Additionally, LACOE should agree to abide by MacLaren policies regarding background checks for those LACOE staff assigned to the facility. Should such an agreement not prove feasible, then MacLaren should review its options relative to alternative providers of educational services at the facility; (Recommendation 110)

3.3 Clarify the California laws and regulations regarding the storage of criminal background checks. Work to ensure that criminal background checks record-keeping is consistent for all employees assigned at MacLaren and that records are auditable; (Recommendation 111)

3.4 Document its policies and procedures relative to background checks and ensure that all County agencies and other parties operating at the facility are aware of these policies and procedures and are in compliance with them; and, (Recommendation 112)

3.5 Document background checks conducted for all contractors and their employees operating at the facility, including those contracted with by DCFS, DMH, DHS and LACOE. (Recommendation 113)

It is recommended that LACOE:

3.6 Immediately conduct background checks on those employees assigned to MacLaren who have not undergone a background check, and document the results of all background checks conducted, with a legal certification as to the truth and accuracy of the information. (Recommendation 114)

COSTS AND BENEFITS

The majority of the recommendations above falls under the overall responsibilities of existing staff, and should not generate additional costs for the facility. The one exception is that the cost of some contractor background checks may need to be borne by MacLaren; however, in general this cost is negligible, relative to the benefit of knowing that only the most qualified staff and contractors have access to the children at the facility. Also, future contractors could be required to have their staffs undergo the background checks before being assigned to MacLaren.

4. Investigating Allegations of Abuse By Staff

- **MacLaren has a number of policies and procedures related to reporting incidents that occur at the facility, including allegations of abuse by staff against children. These policies and procedures are not up-to-date and do not accurately reflect how various incidents are handled at the facility.**

- **A backlog going back to 1997 was found for DCFS investigations of allegations of abuse by staff against children. This backlog has increased over the past two years. DCFS staff report that the reason for the backlog is insufficient staffing and an increase in the number of child deaths elsewhere that required investigation. This backlog situation is critical because it could: 1) result in great harm coming to children at the facility; 2) put the County at risk of lawsuits; 3) give staff the impression that there will be little consequence for abusive behavior toward children, and thus increase the likelihood of future abuse; and 4) cause children to become discouraged and believe that there is no point in reporting the abuse. To improve this situation, DCFS recently assigned a dedicated investigator to MacLaren.**

- **MacLaren's internal staff investigations are conducted by coworkers and have been characterized by staff as perfunctory at best. To ensure the independence and effectiveness of internal investigations, MacLaren needs one individual whose primary responsibility is the investigation of allegations of abuse by staff against children. This position should report directly to the Administrator, and should be required to provide the Administrator with quarterly reports regarding the status and outcomes of investigations. This investigative position should replace the internal investigative responsibilities currently assigned to Children's Services Administrators (CSAs) at the facility. Policies and procedures regarding special incident investigations should be updated to reflect CDSS regulations and other changes made to improve the process, and staff should be trained regarding these updated policies.**

The stated policy at MacLaren Children's Center regarding allegations of abuse by staff against children is that they must be "assessed" within 2 hours, and if there is "knowledge or reasonable suspicion of abuse", then law enforcement is to be notified "immediately or as soon as practically possible." A verbal report is to be followed by a written report within 36 hours.

In addition, the Center's policies and procedures manual instructs Deputy Children's Services Administrators (DSCA), an expired classification which is the equivalent of a Division Director at MacLaren, to submit a report to the "Director" (now Administrator) by the beginning of the next working day regarding various incidents, including:

- Incidents involving serious injury or critical illness affecting a minor, staff member, or visitor, etc. occurring within the facility's jurisdiction

- Major disorders such as riots, extensive destruction of property, group assaults, group AWOLs of four or more minors in one incident, etc.
- Problem situations in which the press, radio or television are involved
- Incidents in which it appears that the Director may be contacted with reference to a complaint or public relations problem

The policies and procedures go on to list several other situations in which a report must be filed, including assault on staff, sexual misconduct, and suicide attempts.

Managers and staff at MacLaren state that the incidents described above also require that a Special Incident Report (SIR) be written by staff involved or witnessing the incident. One incident may generate multiple Special Incident Reports, (e.g., several staff members and a supervisor may write a report on a single incident). These reports are reviewed by the Division Director and subsequently sent to the California Department of Social Services (CDSS). In cases of allegations of child abuse, the reports are preliminarily investigated by Children's Services Administrators (CSAs) and then forwarded to DCFS' centralized Internal Affairs unit.

We found the policies and procedures related to this did not reflect the current process as described to us by staff. For example, no MacLaren documentation reviewed made reference to the role of the Children's Services Administrators relative to child abuse SIR investigations, nor the role of the DCFS Internal Affairs unit in such investigations.

State licensing regulations specify reporting requirements regarding various "events" occurring at the licensee's facility, including client deaths, client injuries, any "unusual incident or client absence which threatens the physical or emotional health or safety" of the client, any suspected physical or psychological abuse of any client, epidemic outbreaks, and several other categories. Reports are to be filed the next working day followed by a written report within seven days.

Exhibit 4.2 shows the number of SIRs filed in the past three years. The focus of this section is the first category, i.e., Staff against Resident Abuse Allegations.

Exhibit 4.2

Special Incident Reports By Category for the Past Three Calendar Years

Type of Allegation	1999	2000	2001	Total
Staff against Resident Abuse Allegations	22	35	53	110
Resident against Resident Assaults	446	717	575	1,738
Resident against Resident Attempted Assault	101	286	271	658
Resident against Staff Assault	445	672	796	1,913
Resident against Staff Attempted Assault	306	614	634	1,554
Total	**1,320**	**2,324**	**2,329**	**5,973**

Source: MacLaren Staff

BACKLOG OF INVESTIGATIONS OF CHILD ABUSE ALLEGATIONS

According to discussions with MacLaren and DCFS staff, as well as a review of the various MacLaren and CDSS policies, there are three types of investigations that are currently supposed to occur when there is an allegation of abuse by staff against children at the facility:

- A police investigation, which is focused primarily on criminal issues
- A DCFS investigation, which is focused primarily on child abuse issues
- An internal MacLaren investigation, which is focused primarily on MacLaren policies and procedures

MacLaren management reports that police reports were completed for all allegations of abuse by staff against children in at least the past year and a half[1]. None of these reports resulted in substantiated criminal allegations, according to MacLaren management.

The internal MacLaren investigations also are up-to-date, according to MacLaren management and some could reportedly result in actions against staff. The reasons that these internal investigations could result in actions against staff, despite the lack of criminal findings by the police, is that staff may have violated internal policies and procedures, such as the timing of bringing children to the clinic for medical care or the timing of actually producing a SIR.

[1] This is the period of time that the current Director of the Boys Division has been assigned at MacLaren, and therefore the timeframe with which he was most familiar.

A backlog of up to four years exists in the DCFS investigations of alleged abuse by staff against children in the facility. These investigations are particularly important because they are focused specifically on child abuse issues, and may differ in their findings from the police findings and/or the internal MacLaren reports. The backlog DCFS investigations became larger over the past two years. Exhibit 4.3 below reflects the backlog of these cases.

Exhibit 4.3

Backlog of Investigations Alleging Abuse by Staff Against Children at MacLaren Children's Center

Calendar Year	Number of Cases Not Yet Investigated
1997	2
1998	7
1999	7
2000	19
As of October 2001	49
Total	**84**

Source: MacLaren Management

In response to inquiries regarding the backlog, DCFS's centralized Internal Affairs staff indicated that the increase in the backlog of investigations is the result of several factors, including insufficient staffing, and an increase in the number of high priority investigations, such as child deaths[2]. They also said that they now have assigned two staff members to focus on these investigations, and that it would take at least five months to eliminate the backlog.

Several MacLaren and DCFS staff report that the preliminary internal investigations of allegations of child abuse conducted by CSAs at MacLaren are at best perfunctory, and that the CSAs assigned to them tend not to give them due diligence because often the allegations are against employees who happen to be friendly toward them, and who would be alienated and respond negatively to them in the future should they exercise the full extent of their investigatory authority. In addition, DCFS Internal Affairs staff report that an atmosphere of silence pervades many MacLaren staff interviewed for investigations, and that an unwritten agreement seems to prevail, wherein staff understand that if they talk, they will not get the backing of their colleagues, should a major altercation with children take place.

Since the DCFS investigations have represented the most comprehensive child abuse investigations at MacLaren to date, the fact that they are backlogged sends a signal to staff that allegations against them by children will be not be vigorously investigated. This could result in reoccurrences of abusive behaviors. Also, children who are victimized may come to believe that little will be done about their complaints, and may become disheartened and endure the abuse without filing complaints.

[2] According to documents provided by DCFS, there were 88 child deaths in 2000 that required a departmental investigation. (All deaths of children of whom the Department had prior knowledge must be investigated by the DCFS Internal Affairs group, according to the group's Senior Manager.)

In addition to potentially causing a great deal of harm to children, this situation also could place the County at risk of lawsuits, such as the class action suit that was filed recently against the County on behalf of six current and former children at MacLaren.

CONCLUSIONS

Investigations of allegations of abuse by staff against children at MacLaren are not adequately addressed. In addition to potentially causing great harm to children, this also could place the County at risk of lawsuits. The policies and procedures related to other "special incidents" at the facility are not well documented and updated to include relevant regulations from CDSS and other procedures important to the day-to-day management of this component of the operations.

The backlog in DCFS investigations adversely impacts MacLaren operations from a number of perspectives, and must be addressed. MacLaren also needs to do a more effective job with its own internal staff investigations that are conducted by coworkers and have been characterized as perfunctory at best. Therefore, while DCFS needs to meet the legal obligation of child abuse investigations, MacLaren should still conduct its own rigorous internal investigation and take corrective action where appropriate.

The best reporting relationship for an internal investigative position at MacLaren from an organizational perspective is a direct one to the Administrator. Should the findings of an investigation lead to recommendations of disciplinary actions against the employee, then some coordination between the personnel unit and the Administrator's office will need to take place.

RECOMMENDATIONS

Based on the findings above, it is recommended that the MacLaren Children's Center Administrator:

4.1 Relieve the Children's Services Administrators (CSAs) currently conducting the preliminary investigations of this duty, as their positions and reporting relationships do not provide the independence necessary to perform this function effectively; (Recommendation 115)

4.2 Assign a manager, preferably one with investigations/auditing skills, to focus primarily on investigations of allegations of abuse by staff against children at the facility. This individual should have complete independence and autonomy from all other managers and staff at the facility and should report directly to the Administrator; (Recommendation 116)

4.3 Direct the new investigator to conduct timely investigations and prepare timely, complete and accurate reports and to produce a quarterly report to be presented to the Administrator regarding the status and outcomes of activities in this area for that quarter; (Recommendation 117)

4.4 Use the quarterly as well as individual investigations reports to ensure that the investigations are being managed in a timely and effective fashion, and problems corrected; and, (Recommendation 118)

4.5 Update MacLaren's policies and procedures relative to Special Incident reporting, including the timeframes and documentation component, and key personnel involved in the process. The policies also should address the code of silence among staff, and put forth concrete consequences for anyone found to have obstructed an investigation of allegations of abuse by staff against children at the facility. This update should include a training element, during which staff are instructed on the policies and procedures and about the importance of timely and proper documentation. (Recommendation 119)

It is recommended that the Interagency Children's Services Consortium:

4.6 Direct DCFS to continue to address the investigation backlog and give it the highest priority. DCFS should be instructed to report back to the Consortium within six months as to the status of the backlog. (Recommendation 120)

COSTS AND BENEFITS

The primary additional costs associated with this recommendation are the salary and benefits costs of the Children's Services Administrator assigned to conduct investigations of allegations of abuse by staff against children. This cost ranges from approximately $70,000 to $115,000 annually[3]. This cost should be at least partially, if not fully, offset by reductions in CSA staff time now spent on internal investigations. The benefits gained by keeping up to date with such investigations, including preventing harm to children at the facility and decreasing the risk of lawsuits, far outweigh any incremental costs. Existing staff could potentially be reassigned to this function to avoid hiring new staff.

[3] These figures are based on salary and benefits ranges for the CSAI through CSAIII classifications, and assume a 30 percent benefits ratio.

5. Recruitment, Hiring and Item Control

- **The decentralized nature of human resources management at MacLaren has led to complications and inefficiencies, and illustrates the difficulty in trying to provide integrated services by various County departments and agencies. Additionally, the Consortium Operational Agreement contains many provisions that limit the Administrator's authority to the detriment of overall effectiveness in managing the human resources function.**

- **Examples of difficulties experienced as a result of decentralized human resources management include the lack of direct input by the Administrator into hiring decisions of LACOE staff assigned at MacLaren; high turnover in key management positions in the Health Services function; disagreement regarding reporting relationships and roles and responsibilities of key management positions in the Health Services function; disagreement regarding the hiring and management of nursing staff; and a lack of accurate item, or position/control data that would enable management to account for all staff at the facility at any given time.**

- **The MacLaren Administrator needs final decision making authority regarding the staffing types and levels at the facility, as well as disciplinary authority. This would increase the efficiency and effectiveness of the overall operation as it would centralize authority and responsibility for key human resources decisions, the major element driving operations at MacLaren.**

The Operational Agreement governing the Interagency Children's Services Consortium and operations at MacLaren spells out the responsibilities of each respective department or agency and the MacLaren Administrator. Given the complex nature of this coordinated effort, the agreement contains many caveats and exceptions as to the Administrator's roles and responsibilities, making the recruitment, hiring, and management of the human resources function extremely complex and difficult.

For example, the Operational Agreement states that:

> "The Administrator, for purposes of administration of MacLaren, including but not limited to personnel administration, shall be the subordinate of each department head who assigns personnel to MacLaren…"

And later:

> "The MacLaren Administrator…is responsible for managing the day-to-day operations at MacLaren…However, in recognition of medical licensing standards, the MacLaren Administrator shall not administer or oversee the clinical practices of physicians at MacLaren…the MacLaren Administrator …has delegated authority to impose discipline…except with respect to medical staff…and except with respect to LACOE staff…"

Then:

> "Based on this delegated authority, the MacLaren Administrator is responsible for all operations at MacLaren…Responsibility for the DCFS MacLaren Unit and the DCFS Resource Utilization Management Unit which are housed at MacLaren remains with the DCFS Director."

While in practice, we found that the parties generally showed a genuine desire to cooperate with one another, the very complexity of the task often made cooperation difficult and frustrating. Although human resources management is just one part of the overall management of the facility, it does illustrate the difficulties the facility experiences in trying to provide integrated services.

Exhibit 5.1 illustrates who is involved in each aspect of the process of recruitment, hiring and background checks at MacLaren:

Exhibit 5.1

Recruitment, Hiring and Background Checks At MacLaren

Department/ Agency	Recruitment	Testing/Screening	Interviewing	Hiring	Background Checks
DCFS	MacLaren/DCFS	DCFS/ MacLaren/DHR	DCFS/DHR/ MacLaren	DCFS/ MacLaren	MacLaren
DMH	DMH/DHR	DMH/DHR	DMH/ MacLaren	DMH/ MacLaren	MacLaren
DHS	DHS	DHS	DHS[1]	DHS/ MacLaren	MacLaren
LACOE	LACOE	LACOE	LACOE	LACOE	LACOE
Contractors	Contractor	Contractor	Contractor	Contractor	MacLaren

Source: Interviews with various MacLaren and Consortium staff and file review

COMPLICATIONS WITH DECENTRALIZED H.R. FUNCTION

Given the decentralized nature of the responsibilities to recruit and hire staff that work at MacLaren, the process can be cumbersome and does not always lead to a group of individuals tailored to the unique needs of the facility. For example, as the table illustrates, the process for hiring and conducting background checks of LACOE staff is performed entirely by LACOE. Given this, the Administrator and his or her staff have at best only indirect input as to who is hired at the facility, via discussions with LACOE administrators at MacLaren.

In addition, this situation has led to difficulties in the management of Health Services staff. Health Services at MacLaren falls under the LAC+USC Medical Center, Chief of Pediatrics. The MacLaren Health Services group reports directly to the Medical Director of the Violence

[1] We were told by the Interim Personnel Officer that discussions are currently underway to enable the MacLaren Administrator to participate in interviews of DHS management positions assigned to MacLaren.

Intervention Program (VIP). The Health Department management responsible for MacLaren has had discussions with the interim MacLaren administration regarding the issues of hiring and management of staff at the facility. The VIP group also developed a proposed staffing plan in September 2001 and submitted it to the previous Administrator of MacLaren at that time. To date, no agreement has been reached regarding this proposed plan.

Also, there has been high turnover among the key positions in Health Services at MacLaren, i.e., the lead Physician and Nurse Manager positions. Within the past three years, there have been three lead Physicians and three Nurse Managers assigned at MacLaren, according to human resources staff at LAC+USC. And, at the time we began this review, the Nurse Manager position was vacant, and the lead Physician was working on an "hourly as needed" basis. The "hourly as needed" classification essentially means that the position is technically "temporary" and may be eliminated at any time. In addition, such staff are not eligible for many of the benefits of many other types of classifications, such as paid vacations and holidays. During our review, we found that the current lead physician has worked an average of 235 hours monthly, or approximately 59 hours per week for the past year.

Another issue creating difficulties in the management of the Health Services operation at MacLaren is the lead Physician's status and reporting relationships. There is disagreement and misunderstanding surrounding this position, including whether that person is responsible for ultimate managerial authority over the Nurses and Nurse Manager assigned to MacLaren. DHS managers and staff we spoke with indicated that they believe that the Nurse Manager and lead Physician must report to the Medical Director of the VIP in conjunction with the MacLaren Administrator, so as to ensure that all legal and administrative requirements are met. They indicated that they believe the Nurse Manager should report to the VIP Medical Director but work cooperatively with the Physician. Thus far, it appears that this arrangement has not worked effectively at MacLaren.

Also, according to the Chief of Pediatrics and the Medical Director of the VIP, the Operational Agreement signed in September is not workable relative to the hiring and management of nurses. They do not believe that MacLaren staff have the expertise required in the credentialing, quality improvement and other aspects required by law to manage the nursing staff, and this arrangement could lead to lack of compliance with regulatory and legal mandates.

Another complication attributable to the decentralizing of recruitment, hiring and management of the human resources component at MacLaren is the inability of MacLaren human resources and budget staff to obtain an accurate, up-to-date and complete count of staff assigned at MacLaren at any given time, what is known at the County as "item control". One of the issues here is that while MacLaren staff now are notified regarding new hires, particularly for those staff whose background checks are the responsibility of MacLaren, notifications regarding resignations, retirements and other departures are not regularly made. No one at Maclaren has a complete up-to-date listing of all employees working at the facility. Thus, it took the audit team considerable time and effort to determine the approximate number of staff at the facility by area and responsibility.

Item control is essential to the efficient and effective management of any organization, and impacts the organization's ability to ensure the safety and welfare of children and staff there. It affects many issues, including security, shift coverage, medical staff coverage, among many other elements of the operation. Without a complete and accurate item control, the facility cannot be sure it is managing the facility optimally.

CONCLUSIONS

The decentralized nature of the human resources function at MacLaren has resulted in numerous complications. Among these are: the inability of MacLaren management to control the type and level of staffing at the facility; various problems in the areas of Health Services, including high turnover and disagreements regarding reporting relationships and staffing decisions; inability to keep accurate item control, with the result being no one at the facility able to provide an accurate accounting of the number and types of staff assigned to MacLaren at any given time. These complications have lingered for years because, given the decentralized nature of the operations, no one has been held accountable for the its overall efficiency and effectiveness.

RECOMMENDATIONS

It is recommended that the Interagency Children's Services Consortium:

5.1 Increase accountability and overall efficiency and effectiveness at MacLaren by revising the Operational Agreement to include more specific and detailed agreements with all parties assigned to the facility, giving the MacLaren Administrator final decision making authority as to staffing types and levels at the facility, including disciplinary actions up to and including dismissal from the facility; (Recommendation 121)

5.2 In areas in which specific expertise is required to make efficient and effective staffing decisions, MacLaren should have its own experts, either on staff or as consultants, who can advise management as to the best configuration; (Recommendation 122)

5.3 Review options for using non-County service providers who are more able or willing to work within the proposed management framework and transfer current County costs to that provider from the department or agency in question should one of the entities be unable or not wish to participate in the recommended amendments to the Operational Agreement; (Recommendation 123)

5.4 Require staff from all agencies to report monthly to the Human Resources Director at MacLaren regarding the total staffing from their department, including new hires, resignations, terminations and transfers. Those agencies not complying with this requirement should be reviewed for suitability to continue their assignment at the facility. (Recommendation 124)

COSTS AND BENEFITS

The primary costs associated with the above recommendations relate to the expertise that might be required to provide MacLaren administration with the appropriate analyses and recommendations regarding staffing at MacLaren. However, it is quite possible that such expertise could actually lead to a net reduction in costs for the County, because of savings associated with different staffing configurations.

The key benefit of the recommendations is that they would lead to more accountability at the facility. By giving the Administrator the authority over all personnel decisions at the facility, the County would also be vesting all responsibility for these decisions with the Administrator. This should lead to increased efficiency and effectiveness at MacLaren.

5. Recruitment, Hiring and Item Control

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- **Examples of difficulties experienced as a result of decentralized human resources management include the lack of direct input by the Administrator into hiring decisions of LACOE staff assigned at MacLaren; high turnover in key management positions in the Health Services function; disagreement regarding reporting relationships and roles and responsibilities of key management positions in the Health Services function; disagreement regarding the hiring and management of nursing staff; and a lack of accurate item, or position/control data that would enable management to account for all staff at the facility at any given time.**

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DHS	DHS	DHS	DHS[1]	DHS/ MacLaren	MacLaren
LACOE	LACOE	LACOE	LACOE	LACOE	LACOE
Contractors	Contractor	Contractor	Contractor	Contractor	MacLaren

Source: Interviews with various MacLaren and Consortium staff and file review

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RECOMMENDATIONS

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5.3 Review options for using non-County service providers who are more able or willing to work within the proposed management framework and transfer current County costs to that provider from the department or agency in question should one of the entities be unable or not wish to participate in the recommended amendments to the Operational Agreement; (Recommendation 123)

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COSTS AND BENEFITS

The primary costs associated with the above recommendations relate to the expertise that might be required to provide MacLaren administration with the appropriate analyses and recommendations regarding staffing at MacLaren. However, it is quite possible that such expertise could actually lead to a net reduction in costs for the County, because of savings associated with different staffing configurations.

The key benefit of the recommendations is that they would lead to more accountability at the facility. By giving the Administrator the authority over all personnel decisions at the facility, the County would also be vesting all responsibility for these decisions with the Administrator. This should lead to increased efficiency and effectiveness at MacLaren.

6. Cost/Staffing Analysis

- **MacLaren Children's Center is a very high cost facility that serves children with great needs. But management does not have control over or complete information about total costs at the facility. Nor are systems in place for measuring the outcomes when new services or staff are added. Without such measurement and without basic financial information, MacLaren management is not accountable for total facility costs nor in a position to assess the effectiveness of services provided relative to costs to ensure that it is providing the most effective services to its residents for the dollars spent.**

- **By extracting information from each agency's financial system for this management audit, consolidated actual MacLaren expenditures in FY 2000-01 were identified as $37,713,970 or $728 per child per day. For the current fiscal year, 2001-02, total costs are projected to be approximately $41.2 million, or $757 per child per day and $276,305 per child per year. Costs are expected to be even higher in FY 2002-03 based on preliminary budget proposals which call for more new positions and other increases beyond cost of living adjustments. The Department of Children and Family Services' share of the cost per child per day is approximately $471. In comparison, the same cost for the Children's Shelter in Santa Clara County which has a similar population mix and size, is approximately $250 per day.**

- **The Interagency Children's Services Consortium has given the MacLaren Administrator authority over all operations at the facility but this authority has not been accompanied by financial control or basic financial information needed to make management decisions. Expenditure levels for three of the four agencies at MacLaren are decided by the parent agencies themselves, not MacLaren management. None of the three agencies report their actual expenditures to MacLaren management. As a result, decisions regarding staffing, service levels and other aspects of operating the facility such as procurements are made without appropriate fiscal consideration by MacLaren management. Contracting for services should be considered as one means of gaining control over service levels and costs.**

The 1998 Memorandum of Understanding (MOU) establishing the Interagency Children's Services Consortium delegates "direct authority and responsibility for all on site multiagency service delivery to children at MCC" to the facility Administrator.[1] While this concept is consistent with the County's move toward integrated and coordinated services for MacLaren residents, the Administrator's ability to be fiscally accountable is limited due to the absence of a complete budget for the facility or a system to track total costs. The Administrator must make decisions about funding, staffing allocations, and adding or changing services without baseline cost information. There is

[1] This Memorandum of Understanding was signed in October 1998, or in FY 1998-99.

no system in place at MacLaren for measuring actual costs of services compared to budgeted, a basic management tool.

A new Administrative Services Manager position was added to the MacLaren staff in 2001 and she has attempted to create a consolidated list of all budgeted positions and their salaries for FY 2001-02 and 2002-03. This document is a start but it is not a full facility budget. It is a long way from allowing management to be fully informed of and accountable for total facility costs for the following reasons:

- It does not include any Los Angeles County Office of Education positions
- It does not include employee benefits costs
- It does not include services and supplies (non-personnel) costs for any of the agencies as these are not reported to MacLaren management by the agencies
- The accuracy of the roster of employees is disputed by some of the managers at MacLaren for their divisions and units.

The absence of a consolidated budget stems from MacLaren's history as a division of the Department of Children and Family Services (DCFS) with the Departments of Mental Health and Health Services and the Los Angeles County Office of Education (LACOE) providing services on site, but not as part of the same organization. MacLaren Children's Center was a separate budget unit when it was part of DCFS so that agency's costs are separately identified and tracked. The same is true for the on-site school operated by the Los Angeles County Office of Education (LACOE) but LACOE's costs are not reported to MacLaren fiscal staff for use in a consolidated facility budget or expenditure tracking system.

MacLaren Children's Center is not a separate cost center for the Departments of Mental Health or the Department of Health Services but are subcenters within larger cost centers for both agencies. Neither agency tracks or reports their MacLaren costs to MacLaren management though they can be extracted from their financial systems. DMH and DHS staff at MacLaren can be reassigned by headquarters management of both agencies. Such changes are not systematically reported to MacLaren, making position control and salary cost information difficult to track.

With the exception of DCFS, budgeted and actual expenditure information for all agencies had to be collected separately from fiscal staff from each of the major agencies that provide services at MacLaren for this audit. There are some significant inconsistencies from year to year and between budgeted and actual data for some of the agencies as this information was extracted from different sources. Given those limitations, the cost estimates presented below represent the best efforts of the auditors and the agencies to identify their costs for services at MacLaren.

Total consolidated expenditures for the major agencies providing services at MacLaren Children's Center is estimated to have been $37.7 million in FY 2000-01. Total expenditures for the current fiscal year, 2001-02, are estimated to be $41.4 million, representing a 9.8 percent increase over the previous year. For Fiscal Year 2002-03, the

proposed budget is expected to increase even further. The Department of Children and Family Services component of the budget alone is proposed to increase by approximately $9 million. Without even considering increases in the budgets of the other agencies, costs would increase by at least 21 percent if the budget is adopted as proposed and fully expended in FY 2002-03. Exhibit 6.1 shows estimated actual expenditures for FY 2000-01 and 2001-02 and the average cost per child per day for each year.

Exhibit 6.1
Total Estimated Expenditures for FY 2000-01 and 2001-02
MacLaren Children's Center

Department	Actual FY 00-01	Estimated FY 01-02*
Children & Family Services	$25,652,374	$30,725,033
Mental Health	$6,362,769	$4,565,368[2]
County Office of Education	$2,533,909	$1,955,194[3]
Chief Administrative Officer	$306,788	$306,788
Health Services	$2,858,130	$3,614,362
Total	**$37,713,970**	**$41,166,745**
Avg. Number of Children	142	149
Cost per Child per Year	$265,591	$276,287
Cost per Child Per Day	$728	$757

Source: Expenditures: each department
Population: "Daily Population for the Month"; Interagency Children's Services Consortium

As can be seen in Exhibit 6.1, the average cost per child per day was $728 in FY 2000-01, for which full year data is available. The projected rate for FY 2002-03 is $757, or approximately 4 percent higher. This is less than the $923 per child per day amount published in a local newspaper. The $923 cost was based on an analysis prepared by MacLaren staff using estimated budged costs as opposed to actual expenditures.

There are 603.7 full-time equivalent positions (FTEs) budgeted for the facility for FY 2001-02, as follows:

[2] Annualized based on actual costs of $2,282,684 as of December 31, 2001.
[3] Annualized based on actual costs of $1,221,996 as of February 12, 2002.

Exhibit 6.2
MacLaren Staffing by Division

Department	Adopted Budget FY 01-02	Percent of Total
Chief Administrative Office (CAO)	3.0	0.5%
Department of Children and Family Services (DCFS)	436.0	72.2%
Department of Health Services (DHS)	24.0	4.0%
Department of Mental Health (DMH)	109.7	18.2%
Los Angeles County Office of Education (LACOE)	31.0	5.1%
TOTAL	**603.7**	**100.0%**

Source: MacLaren Children's Center staffing report

Of the total $37.7 million in costs, approximately $3.4 million is estimated to be costs related to operating the facility. This is comprised of buildings and grounds maintenance, utilities, and some one time costs such as architectural services.

Explanations of the key cost components for each department are now presented.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

The Department of Children and Family Services (DCFS) has the largest total expenditures of all departments at MacLaren as shown above in Exhibit 6.1 The table below, Exhibit 6.3, summarizes DCFS expenditures for the current and previous two fiscal years. The table shows that costs are projected to increase by 33.1 percent by the end of FY 2001-02 compared to two years prior. Increases have occurred in all three budget categories, with the largest increase, 76.5 percent, in Services and Supplies.

Exhibit 6.3
DCFS Expenditures
FY 1999-00 – 2001-02

	FY 1999-00	FY 2000-01	FY 2001-02*	% Change
Salaries and Benefits	$19,129,591	$20,533,879	$24,087,033	25.9%
Services and Supplies	$3,702,239	$5,118,495	$6,534,000	76.5%
Fixed Assets and Equipment	$61,290	$0	$104,000	69.7%
Total	**$23,083,392**	**$25,652,374**	**$30,725,033**	**33.1%**
Authorized Positions	366	366	436	19.1%

* Estimated

Source: FY 1999-00 and 2000-01: Chief Administrative Office expenditure reports
FY 2001-02 Estimate: Interagency Children's Services Consortium 2002-03 Budget Request

SALARIES AND BENEFITS COSTS

As in most public agencies, salaries and benefits costs comprise the majority of expenses for DCFS. With 436 full-time equivalent positions (FTEs) authorized for FY 2001-02, DCFS also contributes most of the employees at MacLaren. Most of the DFCS positions are Children's Social Workers or Group Supervisors, the core staff that provides direct services to the facility residents. Besides direct supervision in the cottages, some of these positions are also used for the Wraparound program, admissions, one-on-one supervision[4] and the new case management services.

With 292 authorized Children's Social Workers and Group Supervisors, the agency should have the equivalent of an average of 59 of these positions on staff at any time during the year. With an average daily population of 149, this is a very high level of staffing, a ratio of one Children's Social Worker/Group Supervisor for every 2.5 children. Of course, not all authorized positions are filled, and some of these positions are used for other functions. But the goal of management is to have five Children's Social Workers and/or Group Supervisors on duty for each shift for each cottage. Since there are nine cottages, this translates into 45 positions on duty at any one time without counting others assigned to other functions. With an average of 16.6 children per cottage, five workers on duty per shift equates to a ratio of one worker for every 3.3 children. This is considered baseline staffing and is not always achieved due to vacations, sickness, and vacant positions. Additional Children's Social Worker/Group Supervisor staff is used for one-on-one supervision. MacLaren managers report that there are 40-50 children receiving one-on-one supervision at any one time, adding considerably to the demand for positions. Because there usually aren't enough filled positions to provide baseline staffing and one-one services simultaneously, overtime is used for one-on-one services.

While the needs of the children at MacLaren Children's Center are very great, as discussed in Section 2 in the profile of the population, this is a very high level of staffing. The key question about incurring this cost is whether it is producing desired results. By tracking indicators such as Incident Reports, MacLaren management should be able to report if certain behaviors are decreasing, such as incidents of assault, suicide attempts and destruction of property. The Incident Report data in Section 2 of this report showed that the number of Serious Incident Reports increased between Calendar Year 1999 and 2001. The number of reported incidents in 2001 was 2,329, which was about the same as in 2000, when it was 2,324. However, in the previous year, 1999, the number was only 1,320. The number of child assaults on staff increased over the three year period whereas the number of child assaults on other children decreased. It is not possible to draw a conclusion from these gross numbers about the effectiveness of cottage staffing but this should be a rich source of data in measuring outcomes and the effectiveness of the high level of staffing and one-on-one supervision.

[4] One-on-one services are when a Children's Social Worker is assigned to be with just one child at a time who has threatened or demonstrated violent or harmful behavior. These sessions can last for anywhere from one to several days.

In addition to a high base level of staffing, the increases shown in Salaries and Benefits costs in Exhibit 6.3 reflects additional positions being added, and increased overtime costs, as well as cost-of-living increases in existing employee salaries. In FY 2000-01, the number of DCFS positions at MacLaren was increased by 70, from 366 in FY 1999-00, to 436. An additional 39 positions were requested as mid-year budget adjustments for FY 2001-02, which will result in a total DCFS authorized position count of 475. Among the reasons for these additional positions are:

- Additional Children's Social Workers and Supervising Children's Social Workers for increased cottage staffing and to provide one-on-one services
- New on-site case managers service for every resident
- Additional clerical staff to support line staff
- Additional managers to oversee training and other functions
- Staff for transferred and expanded administrative functions previously provided centrally by DCFS such as personnel administration, procurement and budgeting

As with the need for measurement of the effectiveness of the core staff discussed above, similar measurements are needed for new positions and services being added. For example, seventeen new Children's Social Worker positions were added in FY 2001-02 to serve as on-site case managers for each child at MacLaren. This is in addition to the regular DCFS Social Worker that all children in the child welfare system are assigned. It is also in addition to DMH case managers already on staff at MacLaren. The concept was to have staff whose primary purpose is making sure that each child obtains the services they need while at MacLaren and after they leave. This is also the role of the DCFS Social Worker though many at MacLaren and at DCFS report that Social Workers are very overworked and cannot put the necessary time in to effectively serve the needy children at MacLaren. In any case, the effectiveness of this new service should be measured to determine if the additional costs are justified.

OVERTIME COSTS

Besides its high number of positions, DCFS incurs a substantial amount of overtime costs that is included in its Salaries and Benefits expenditures. As shown in Exhibit 6.4, the facility has been incurring high overtime costs ranging from approximately $3.1 million in FY 1999-00 to an estimated $4 million by the end of FY 2001-02 based on actual expenditures through the end of January 2002. Not only is this a significant amount, it is well over the amounts budgeted for each of the three years presented in Exhibit 6.4.

Exhibit 6.4
Overtime Costs at
MacLaren Children's Center
FY 1999-00 – 2001-02

	FY 1999-00	FY 2000-01	FY 2001-02[5]
Actual Expenditures	$3,152,854	$3,270,918	$4,011,461
Budgeted Amount	1,117,000	3,000,000	1,500,000
Difference	$2,035,854	$270,918	$2,511,461

Source: Chief Administrative Office expenditure reports

The primary use of overtime is for residential services, which means for extra staff providing direct care and supervision to MacLaren's cottage residents. Prior to FY 2001-02, DCFS tracked overtime by three categories: residential services; support services; and, administration. The bulk of overtime expenditures fell in to the residential services category. While this is still true, starting in FY 2001-02, MacLaren staff has added some new categories to better track overtime. The result is that the amount in Residential Services appears to be declining in FY 2001-02 but it probably included inappropriately classified expenditures in the prior two fiscal years. Exhibit 6.5 presents detailed expenditures as classified by MacLaren for the three fiscal years.

Exhibit 6.5
Breakdown of Overtime Expenditures
FY 1999-00 – 2001-02

	FY 1999-2000	FY 2000-2001	FY 2001-2002 (7 mos.)	FY 2001-02 (projected)
Residential	$2,950,007	$3,057,072	$1,315,382	$2,254,941
Administration	$27,845	$35,349	$288,057	$493,812
Transitional Services			$350,139	$600,238
Training			$268,075	$459,557
General Services			$59,849	$102,598
Volunteer Coordination			$39,745	$68,134
MacLaren Children's Center			$18,613	$31,908
Reserved			$159	$273
Support Services	$175,002	$178,497		$0
Total	$3,152,854	$3,270,918	$2,340,019	$4,011,461

Source: Chief Administrative Office expenditure reports

Overtime costs for Training, Administration and Transitional Services are explained by MacLaren staff as the result of obtaining a State license for the facility in 2001 which required increases in staff training. The increase in Administration costs were largely attributed to performing an inventory of items in the MacLaren warehouse and staff

[5] Annualized based on $2,340,019 in actual overtime expenditures for the first seven months of FY 2001-02.

working to complete Live Scan background check results. Transitional Services costs are reportedly for Wraparound and the new Case Management services at MacLaren.

The new General Services overtime category includes facility service, such as laundry and kitchen services. Volunteer Coordination is an additional new category with overtime costs in the current fiscal year. This is a small unit within MacLaren and works overtime when a special event is planned, generally on weekends.

ONE-ON-ONE SUPERVISION

A major component of Residential Services overtime costs is for One-on-One Supervision. As mentioned earlier, this is when a cottage staff person, either a Children's Social Worker or a Group Supervisor, is assigned to and stays with only one child for a certain amount of time because the child appears to be a danger to him or herself, others or the facility. One-on-One assignments are primarily determined by cottage staff, though they are occasionally court-ordered and in many cases are originally ordered by mental health staff during intake. Often, the children themselves request it, according to MacLaren staff. The duration of these assignments is also determined by Residential Services staff and usually lasts from one to seven days. This intensive level of supervision represents a significant cost to MacLaren.

To illustrate the fiscal impact of extensive One-on-One services, Exhibit 6.6 presents actual overtime costs attributed just to One-on-One supervision for a recent eight day period. DCFS staff developed these approximate estimates of overtime costs for One-on-One Supervision staff at MacLaren during the period from March 3 to March 11, 2002. The data, as shown in Exhibit 6.6, indicates that $92,972.84 was spent during that period on Overtime costs for just One-on-One Supervision, representing 2,418 staff hours. This is slightly more than the equivalent of one position for an entire year.

Exhibit 6.6
One-on–One Supervision Overtime Costs
March 3, 2002 to March 11, 2002

Item	Overtime Hours Paid	Hourly Rate	Time and one Half	Total
SCSW	144.5	$31.03	$46.54	$6,725.59
CSW	1,588.0	$27.70	$41.55	$65,984.14
CSW A/N	75.0	$27.70	$41.55	$3,116.38
GS II	221.5	$21.19	$31.79	$7,040.95
GSN	389.0	$17.32	$25.98	$10,105.78
Total	**2,418**			**$92,972.84**

Source: Special report; MacLaren Children's Center

DCFS SERVICES AND SUPPLIES

The area of greatest cost increase within the DCFS budget, Services and Supplies, was approximately $5.1 million in FY 2000-01, up from $3.7 million in FY 1999-00, an increase of $1.4 million or 37.4 percent. Projections for the current fiscal year, 2001-02, are for $6.5 million in expenditures. Details on DCFS' Services and Supplies expenditures are presented in Exhibit 6.7. It should be noted that the total expenditure amounts shown in Exhibit 6.7 are at slight variance with the totals in Exhibit 6.2 above. The detail was available only from the Chief Administrative Officer's budget office and did not include all of the same expenditures as the total available from MacLaren budget staff.

As the data in Exhibit 6.7 below indicates, the three largest non-personnel costs in FY 2000-01 are Building Maintenance and Improvements, Professional and Special Services and Food. These three cost components accounted for 68.1 percent of DCFS' total Services and Supplies costs in FY 99-00 and 72.3 percent in FY 00-01. Building Maintenance and Improvements and Professional and Special Services also represent the largest increases between the two years.

Building maintenance and improvements increased for repairs due primarily to vandalism according to MacLaren staff. This is expected to increase further in FY 2002-03, though MacLaren has secured a new vendor that is to provide unbreakable chairs in the future so this cost should be expected to go down. Also, a decrease in this cost could be one indicator of the success of One-on-One supervision.

Exhibit 6.7
DCFS Services and Supplies Actual Expenditures
MacLaren Children's Center

Expense	FY 99-00	FY 00-01	Change	% Change
Building Maint. & Improvement	$1,073,465	$1,940,966	$867,501	80.8%
Professional & Special Services	$789,861	$1,007,516	$217,655	27.6%
Food	$658,973	$730,169	$71,196	10.8%
Utilities	$348,187	$541,858	$193,671	55.6%
Household Expense	$491,353	$525,271	$33,918	6.9%
Communications	$215,247	$222,726	$7,479	3.5%
Special Departmental Expense	$53,303	$45,420	($7,883)	-14.8%
Clothing & Personal Supplies	$57,718	$43,282	($14,436)	-25.0%
Administrative and General	$4,154	$16,852	$12,698	305.7%
Auto Mileage	$5,263	$11,361	$6,098	115.9%
Auto Service	$3,415	$1,108	($2,307)	-67.6%
Office Expense – Other	$1,300	$906	($394)	-30.3%
Rent & Leases – Equipment	–	$156	-	
Grand Total	$3,702,239	$5,087,591	$1,385,352	37.4%

Source: Chief Administrative Office expenditure reports

Approximately $700,000 of the $1 million expended for Professional and Special Services was for contract as-needed nursing services provided in addition to Department of Health Services staffing at the facility. MacLaren budget staff report that DHS claims they cannot pay for these positions from their revenue sources.

Another high Services and Supplies cost at MacLaren is Utilities, which increased $193,671 or 55.6 percent between FY 1999-00 and 2000-01, due primarily to the energy crisis in California. With the consolidation of MacLaren, the cost of utilities will be shared among the various departments. Payment will be broken down based on the percentage of staff at MacLaren.

DEPARTMENT OF MENTAL HEALTH EXPENDITURES

The Department of Mental Health (DMH) has the second largest expenditures of the four main agencies at MacLaren. Estimated DMH expenditures for FY 2000-01 were approximately $6.3 million. They are projected to decline in the current fiscal year, 2001-02, to approximately $4.6 million, as shown in Exhibit 6.8.

As with all agencies at MacLaren except DCFS, DMH's budget and expenditure information is not tracked by or reported to MacLaren management. To obtain the expenditure data presented in Exhibit 6.8 DMH management at MacLaren assembled current staffing and salary information and DMH's central fiscal staff extracted budgeted and actual costs from their financial system. MacLaren's budget staff reports 110 positions budgeted for DMH services at MacLaren in FY 2000-01. The information from these two sources was discrepant and speaks to the lack of regular monitoring and reporting of budgeted or actual DMH expenditures by either DMH or MacLaren management.

Exhibit 6.8
Department of Mental Health Expenditures

	Fiscal Year 2000-2001	**Fiscal Year 2001-2002[6]**
Salary and Benefits	$5,928,487	$4,377,518
Services and Supplies	$434,282	$187,870
Total	**$6,362,769**	**$4,565,388**

Source: Salaries & Benefits: DMH Staff at MacLaren Children's Center
Services & Supplies: DMH Fiscal reports

A comparison of DMH budgeted and actual expenditures for FY 2000-01, shown in Exhibit 6.9, reveals that the department appears to be over-budgeting for MacLaren Children's Center as actual expenditures were nearly $2 million less than the adopted

[6] Annualized based on actual expenditures of $2,282,684 as of 12/31/01.

budget amount of $8.3 million. Staffing changes and vacancies could explain salary and benefits under-expenditures but the variation raises the question of whether the budget is overstated or whether all costs are being properly charged in the DMH system. This becomes more of a possibility given the fact that DMH's MacLaren costs are not routinely reported and reviewed by MacLaren management.

Exhibit 6.9
Comparison of DMH Budget and Actual Expenditures
Fiscal Year 2000-01

	Adopted Budget	Actual	Difference
Salary and Benefits	$7,277,935	$5,928,487	($1,349,448)
Services and Supplies	$1,052,349	$434,282	($618,067)
Total	**$8,330,284**	**$6,362,769**	**($1,967,515)**

Source: Budget: Adopted DMH Budget
Actual: DMH staff at MacLaren and DMH fiscal reports

As discussed above, a performance measurement system is needed for many of the services and activities at MacLaren. Outcome measures should be developed for mental health services so that management can assess the relative effectiveness of mental health service options for the children at MacLaren. Key indicators should include the number of children admitted to psychiatric hospitals and the number of crisis interventions performed by staff.

DEPARTMENT OF HEALTH SERVICES EXPENDITURES

Like DMH, Department of Health Services (DHS) expenditures presented in Exhibit 6.10 are not regularly tracked and reported to MacLaren. This cost information was not available from MacLaren staff but was extracted from the DHS financial system by DHS fiscal staff at the request of the auditors.

DHS expenditures have increased over the three fiscal years reviewed from approximately $2.4 million in FY 1999-00 to $3.6 million in FY 2001-02, as projected by DHS fiscal staff, an increase of 47.3 percent. Salaries and benefits are projected to increase from approximately $1.8 million in FY 1999-00 to $2.4 million by the end of FY 2001-02, an increase of 39.7 percent. Services and Supplies expenditures are projected to increase by $593,879, or 89.2 percent, between FY 1999-00 and the end of 2001-02. MacLaren's budget staff reports 24 positions budgeted for DHS services at MacLaren in FY 2000-01.

While MacLaren management may have been involved in discussions concerning medical staff resources at MacLaren, information on actual fiscal impacts has not been made available to MacLaren. DHS management continues to control the management structure of the medical services unit even though some MacLaren staff believe that the

unit does not require both a highly paid Nurse Manager to manage the nursing staff and a highly paid physician with no management responsibility for the unit. If MacLaren management had organizational and fiscal control, it could consider various alternatives to obtain the most cost-effective management structure for the unit and put any resulting savings to other uses.

Exhibit 6.10

Department of Health Services Expenditures

Category	FY 99-00	FY 00-01	FY 01-02[7]
Salaries and Benefits	$1,787,674	$1,927,947	$2,350,481
Services and Supplies	$666,002	$930,160	$1,259,881
Other Charges	$0	$23	$4,000
Equipment	$0	$0	$0
Total	**$2,453,676**	**$2,858,130**	**$3,614,362**

Source: Special report produced by LAC+USC Management

DHS records show that most DHS costs are Net County Costs, or not reimbursed by Medi-Cal or other non-County revenue sources. In FY 2000-01, for example, the Department's Net County Costs for services at MacLaren were approximately $1.7 million, or 58.6 percent of total costs. This is another reason MacLaren management should be actively involved in determining the most cost-effective staffing and service levels for its medical services unit as Net County Cost money could be transferred and used for other purposes within MacLaren.

LOS ANGELES COUNTY OFFICE OF EDUCATION EXPENDITURES

As shown in Exhibit 6.11, LACOE expenditures, while increasing slightly, have remained stable over the three-year period. Total FY 2000-01 spending of approximately $2.5 million was approximately $214,641, or 9.3 percent, more than the prior fiscal year. LACOE revenues and spending are determined mostly by average daily attendance at school. According to LACOE, the average daily attendance in FY 1999-00 was 101, while that number increased to 110 in FY 00-01.

[7] This is a forecast amount made in January 2002 by Department of Health Services staff.

Exhibit 6.11
Overall LACOE Expenditures

	Fiscal Year 1999-2000	Fiscal Year 2000-2001	Fiscal Year 2001-2002[8]
Certificated Salaries	$1,081,491	$1,146,739	$744,638
Classified Salaries	$482,393	$571,006	$216,300
Employee Benefits	$420,001	$436,270	$203,760
Books and Supplies	$39,822	$39,566	$19,802
Contract Services and Operating Costs	$26,235	$33,750	$14,236
Capital Outlay	$11,369	$7,662	$0.00
Allocated and Documented Direct Support	$127,603	$151,845	$23,260
Indirect Support -Unlimited	$130,356	$147,072	$0.00
Total	**$2,319,270**	**$2,533,910**	**$1,221,996**

Source: Los Angeles County Office of Education

Several aspects of LACOE expenditures saw significant increases during the period reviewed. The largest increase in LACOE expenditures were in Classified Salaries, such as para-educators, clerical staff, and sub assistants, where expenses increased by $88,613,or 18.4 percent in FY 00-01. Within Classified Salaries, Sub-Assistant salaries increased by 641.7 percent from $13,264 in FY 99-00 to $98,377 in FY 2000-01. LACOE spending on substitute teachers increased by 256 percent, or $79,130 over the two fiscal years. Comparatively, teachers' salaries assigned to MacLaren increased by 14.4 percent. However, these increases were offset by reductions in Counselor salaries (-100 percent or $13,369.80) and teacher special assignments (-63.3 percent or $144,532.45).

LACOE revenues are State funds dedicated to school funding. If MacLaren Children's Center management were able to reduce costs at the school through more control over operations there, the savings would not become available for other purposes at MacLaren. However, MacLaren management should still be involved in reviewing LACOE's costs to monitor for cost-effectiveness. LACOE management reports that the school is currently operating at a deficit.

CAO

The CAO charges for MacLaren are estimates based on data from a number of sources. Of the $306,788 CAO charge to MacLaren, $69,730 is a direct charge to MacLaren for services. These charges range from $28,420 in Integration Services to $22,400 in Budgetary Services to $70 in Legi-Tech Services. The additional costs of CAO to

[8] As of February 12, 2002.

MacLaren are from the Interagency Children's Services Consortium Fiscal Year 2002-2003 Budget request of three budgeted positions at MacLaren. However, according to CAO staff, the $237,418 cost for the positions at MacLaren is distributed across the departments and agencies within the Interagency Children's Services Consortium.

PROCUREMENT AT MACLAREN CHILDREN'S CENTER

The Operational Agreement governing the Interagency Children's Services Consortium and operations at MacLaren explains the mission of the various departments and agencies, as well as the MacLaren Administrator. The Operational Agreement details the MacLaren Administrator's role and responsibility regarding procurement. Specifically, the Operational Agreement states that:

> "The MacLaren Administrator shall also have delegated authority to approve procurement of goods and services related to MacLaren operations."

However, the MacLaren Administrator currently is only involved in the procurement process for the Department of Children and Family Services. Even with the effort to get more cooperation with the various departments at MacLaren, procurement is still handled by the individual departments. This was substantiated through interviews with DCFS MacLaren staff who had no knowledge regarding the procurement policy of other departments at MacLaren.

The Department of Health Services has its own procurement process where items are bought subject to the needs of DHS staff. Once the equipment is identified as needed, DHS staff fills out an internal HS-2 form and the form is sent to LAC-USC for proper authorization. Once at LAC-USC, the forms will receive proper authorization and the request will be analyzed against the Services and Supplies budget by DHS finance staff to confirm funds are available in the budget for the purchase request. Once these steps are successfully completed, the product will be ordered and delivered to MacLaren.

The MCC Administrator is not involved in the procurement process for DHS. There are exceptions, however, where several departments will work together on procurement of large items. For instance, the dental office for MacLaren is in the process of purchasing a new x-ray machine and a dental chair. According to LAC-USC staff, for large purchases needed for the Center, the Administrator will have more direct involvement in the process but final approval authority remains in DHS.

Procurement for the MacLaren school starts with a purchase requisition form from the Principal, Assistant Principal, teachers, or a committee of the principal and teachers. The purchase requisition form is then sent to the Division of Juvenile Court and Community Schools Budget Analyst for verification against the budget. According to LACOE staff, the Budget Analyst will confirm that funds are available in the budget or a staff accountant will complete the process. Once verification is approved, the purchase order will go to the LACOE Purchasing Department or a similar department based on the type

of order. According to LACOE staff, the MacLaren Administrator has no involvement in the LACOE procurement process.

In general, it appears the MacLaren Administrator has limited involvement in the procurement process at MacLaren. There are exceptions, however, and these include DCFS procurement, where the MCC Administrator appears to have more involvement than in the other departments.

To verify that MacLaren DCFS employees were following the proper procurement authorization policy, random samples of procurement files were evaluated for completeness. The types of purchases examined were for food products ranging from meat, bread, and dairy products to fruits and vegetables. Other purchases in the sample were cleaning products, pest control, pillowcases, and helium. To analyze procurement procedures at MacLaren we verified whether the DCFS Form 250 had proper authorization. Currently, authorization can only come from the MCC Administrator, an Administrative Services Manager III in the Administrative Services Division at MacLaren, or her report, a Children's Services Administrator. According to MacLaren staff, the procurement process will not continue unless the DCFS 250 form is properly signed. However, DCFS staff indicated that the MCC Administrator rarely signs the DCFS Form 250 but is kept apprised of procurement. The review of procurement showed the following:

- 86.7 percent of the files had proper authorization on the DCFS Form 250;
- 13.3 percent of the files examined did not contain the DCFS Form 250;
- 100 percent of the procurement files contained the Purchase Order; and
- 100 percent of the files contained the product invoice.

The procurement files were up to date for the current fiscal year. Analysis of procurement files from previous fiscal years was difficult due to the lack of organization and the difficulty in locating earlier files. According to MacLaren staff, this is the direct result of high turnover in the procurement position.

STAFFING AND ORGANIZATION STRUCTURE

Earlier in this report, a change in staffing was recommended that would phase out the extensive use of Children's Social Workers as the core staffing in the cottages and replace most of them with mental health workers such as Licensed Psychiatric Technicians. These would be more effective classifications for the population at MacLaren and would lower costs as their salaries are lower. Use of effective mental health techniques and approaches should also lower the costs now being incurred for the high cost of One-on-One services.

One of the key points of this section is that the MacLaren Administrator does not have control over all costs or service levels at the facility. Contracting for services should be considered as an alternative to the status quo as a means of gaining control over costs and

service outcomes in the event that this cannot be accomplished with the other County agencies that provide services at MacLaren.

Other means of making MacLaren more cost effective would include identifying all new administrative positions and costs related to the consolidation and reducing those costs at the agencies that used to provide those administrative services such as DCFS. Based on the Interagency Children's Services Consortium Fiscal Year 2002-2003 budget request only the Department of Children and Family Services will gain new FTE positions. In particular 39 new positions are proposed for MacLaren within DCFS. Of these 39 new positions, 18 positions will go toward the formation of new administrative functions, as MacLaren becomes administratively independent. The addition of positions should be offset with reductions in positions within the main budgets of DCFS and the other agencies that provide staff at MacLaren. Specifically, the 18 new administrative positions should come from the DCFS Administration budget. However, based on the draft of the proposed changes to the FY 2002-2003 budget from the FY 2001-2002 budget, the 39 new positions are offset by a reduction of only three positions in the DCFS Administration budget.

Other options should be considered including revising the management structure to eliminate duplication and create greater equity in responsibilities among managers. Currently there are seven second level managers from DCFS and DMH (Children's Services Administrators or their equivalent in Mental Health) with a median of 57 total reporting employees. However, three of the positions have well under the median number reporting to them: 12, 23, and 33. To truly consolidate and coordinate services, the barriers between the old agencies should be eliminated and managers should be expected to oversee functions that were previously exclusively under the jurisdiction of one of the agencies. By doing so and making the numbers of staff assigned to managers more comparable, the total number of second level managers could be reduced from seven to at least five.

Salaries do not seem excessively high at MacLaren. A majority of staff salaries at MacLaren falls between the $40,000 and $50,000 salary range. A majority of these positions are DCFS Children's Social Workers. Overall, 91.2 percent of all employees at MacLaren make less than $60,000 a year. The more important issue is the high number of positions, particularly Children's Social Workers/Group Supervisors, the absence of good financial tracking and reporting systems for all costs at MacLaren and the absence of a system for measuring outcomes related to the costs incurred.

CONCLUSION

Though its total costs are very high, MacLaren Children's Center management functions without benefit of basic financial tracking information and systems. A consolidated budget does not exist nor are actual facility-wide expenditures reported to management to ensure accountability and to enable analyses of costs compared to outcomes.

The Department of Children and Family Services (DCFS) has always treated MacLaren Children's Center as a separate cost center so the budget and actual expenditures for the DCFS portion of MacLaren is readily available. Similarly, the school operated on site by the Los Angeles County Office of Education is a separate cost center for that organization and those costs and expenditures are readily available though not reported to the MacLaren Administrator or financial officer. Budgeted and actual expenditures incurred by the Departments of Mental Health and Health Services at MacLaren are not tracked or reported separately and MacLaren management does not routinely receive this information. Decisions and controls regarding staffing levels, procurement of fixed assets and overtime are decided by the parent agencies, not the MacLaren Administrator.

Extraction and compilation of budgeted and actual expenditures for the primary agencies at MacLaren revealed that actual expenditures in FY 2000-01 was an estimated $37,713,970, or $728 per child per day. For FY 2001-02, projected costs per child per day will be $757 or $276,305 per year. With such high costs, it is critical that the MacLaren Administrator and management is informed on all expenditures and has the ability to control costs. In addition, MacLaren management should be responsible for ensuring that any new costs or services are reasonable relative to the services provided. Such systems are not in place at this time though the facility's Operational Agreement delegates "direct authority and responsibility for all on site multiagency service delivery" to the Administrator. To have this level of authority without the benefit of cost information is a poor management practice.

Potential opportunities exist to lower costs without worsening program outcomes through restructuring MacLaren's management structure, consolidating and controlling procurement, and allocating staff and other resources based on outcomes rather than maintenance of the status quo. All of this requires consolidated financial information and reporting and authority and accountability delegated to the Administrator.

RECOMMENDATIONS

Based on the above findings, it is recommended that the Interagency Children's Services Consortium:

6.1 Direct staff to develop a cost tracking and reporting system so that all budget and actual expenditures are consolidated, reviewed and approved by the MacLaren Administrator and reported to the Consortium; (Recommendation 125)

6.2 Direct staff to delegate authority over funding and service levels for all services at MacLaren to the Administrator; (Recommendation 126)

6.3 Revise procurement policies so that the Administrator is responsible and accountable for all procurement at MacLaren; (Recommendation 127)

6.4 Direct staff to design and implement performance measurement systems for measuring outcomes of existing and any new proposed staffing or services; (Recommendation 128)

6.5 Consider alternative staffing levels and approaches to obtain desired outcomes including eliminating barriers between agencies so that managers can assume responsibility for staff from different agencies and the number of managers can be reduced; (Recommendation 129)

6.6 Consider and obtain comparative cost information for contracting for services now provided by various County agencies if they are unwilling to relinquish control over service and staffing levels to the MacLaren Administrator; (Recommendation 130)

6.7 Establish a policy of reducing costs in the parent agencies when administrative functions are transferred to MacLaren; and, (Recommendation 131)

6.8 Obtain comparative cost information regarding contracting for all services at MacLaren. (Recommendation 132)

COSTS AND BENEFITS

Greater fiscal responsibility and cost effectiveness should result from the above recommendations. There would be no new direct costs associated with implementation of these recommendations.

SOCIAL SERVICES COMMITTEE

Los Angeles County
Department of Children and Family Services

BACKGROUND

Early in the process of selecting areas of concern for investigation, the Social Services Committee favored a limited scope review of the Department of Children and Family Services; specifically, the removal of children from the family. However, in order to complete the task, the members opted to engage an independent auditor to perform the bulk of the investigation. The following portion of this report represents the independent auditor's findings.

Introduction

The Harvey M. Rose Accountancy Corporation is pleased to present this *Limited Scope Performance Audit of the Los Angeles County Department of Children and Family Services: Child Abuse and Neglect Investigation and Protective Custody Practices.* This management audit was requested by the Fiscal Year 2001-02 Los Angeles County Civil Grand Jury to assist its investigation of this topic under the authority granted to it by Section 925 of the California Penal Code. The use of experts to assist in the Grand Jury's investigation is permitted under Section 926 of the Penal Code.

In requesting this management audit, the Grand Jury asked that information be gathered on the process used to investigate allegations of child abuse and neglect in Los Angeles County, and to make determinations as to when children should be removed from their custodial parent(s) and taken into protective custody. Among the specific questions asked by the Grand Jury were: How many petitions citing abuse or neglect are dismissed by the Superior Court after children have already been taken out of the home? When petitions are dismissed, how soon are children returned to their homes? Have federal funding requirements impacted the percentage of children removed from their homes? Have time limits on receipt of federal assistance to poor families caused any increase in the number of children being removed from their homes?

Study Scope and Methodology

To assess these questions, and the general subject of abuse and neglect investigations by the Department of Children and Family Services (DCFS), audit staff conducted an entrance conference with the DCFS director and other selected managers to explain the audit process and to gather background information on the Department's structure and the organization of the investigation functions. More detailed interviews were conducted with the Acting Bureau Chief of the Department's Bureau of Child Protection, which is responsible for this function, with selected Bureau administrators and supervisors in various regional offices, and with a random sample focus group of social workers who investigate allegations of abuse and neglect. Audit staff also reviewed the Bureau's business plan, its policy and procedure manuals, DCFS strategic plans and statistics provided by the Department and by the Superior Court.

Because of the limited availability of data on the questions posed by the Grand Jury, audit staff also reviewed case files from 67 cases in October and November 2001 in which children were taken into protective custody, to assess the documentation and analysis gathered by social workers in support of the removal decision. Finally, audit staff also sought data from other California counties in selected areas for comparison to the information provided by DCFS.

Fieldwork on this audit began with an entrance conference on January 9, 2002, and was completed on approximately April 25, 2002. Fieldwork on this project was significantly delayed due to legal requirements imposed by the Superior Court and the Los Angeles County Counsel's Office. First, the Court and County Counsel required a court order be obtained in order to conduct the case file review previously described. The court order was initially requested verbally of the County Counsel for the Grand Jury on January 22, and a written request was made shortly thereafter. The court order was not provided to audit staff until March 4, a delay County Counsel stated was the result of noticing requirements imposed by the Superior Court.

Subsequent to the receipt of the court order, audit staff conducted a portion of the file review from March 11-18, using the electronic case information in the Child Welfare Services/Case Management System (CWS/CMS). However, because key information regarding cases was not maintained in an electronic format, we also requested to review hard copy case files. County Counsel then advised that prior to this review, all case files would have to be copied, and selected information redacted. County Counsel cited the requirements of Evidence Code Section 950 and Code of Civil Procedure Section 2018, regarding confidentiality of attorney-client communications and attorney work products, and the requirements of Welfare and Institutions Code Sections 4514 and 5328, regarding confidentiality of information on services provided for mental health or developmentally disabled clients. County Counsel asserted that the code requirements surmounted the authority granted to audit staff by the Juvenile Court's Presiding Judge to review case file information.

Permission to review the paper case files was initially requested on March 21, to review the files on April 2-4. Because of the County Counsel's redaction requirement, the review could not be conducted until April 16-18, a two-week delay.

Following the completion of fieldwork, a draft report was prepared, and provided to the Department and the Grand Jury on May 3, 2002. An exit conference to discuss the draft report was held on May 13, 2002. Revisions were then made, and the final report was issued to the Grand Jury on May 15, 2002.

The Bureau of Child Protection and Dependency Investigations

The functions assessed in this report are the responsibility of the Bureau of Child Protection, one of four bureaus within the Department of Children and Family Services. The Bureau was created in April 2001 for the purpose of separating the investigation of allegations of child abuse and neglect from other child welfare functions provided by the Department. A Mission Statement developed in July 2001, and included in one of the Department's manuals, states:

The Bureau of Child Protection will provide thorough investigations and prompt initial assessments that will:

- Maximize child safety through improved child abuse investigations
- Minimize the number of detentions (these are removals of children from homes)
- Minimize the number of disrupted placements
- Minimize the amount of time a child remains in the system
- Minimize response time
- Meet legal sufficiency standard on petitions filed

According to the Bureau's business plan, developed in August 2001, current budgeted staffing is 1,375 positions, including 53 administrative staff, 766 social workers, 118 supervising social workers and 438 clerical or support staff. Budget information solely for the Bureau of Child Protection was not readily available. However, Los Angeles County's Fiscal Year 2002-2003 Children and Families Budget includes a multiple program overview for the Bureau and other DCFS programs, estimating FY 2001-02 expenditures will total $537.3 million, with approximately 88.6 percent of the funds coming from non-County sources.

The investigation of child abuse and neglect allegations is a four-step process. A description of each step in the process follows, and a flow chart of the process is included at the conclusion of the Introduction.

Child Protection Hotline

Allegations of child abuse and neglect are usually reported initially by telephone to the Child Protection Hotline. This is a centralized answering center where social workers, generally known as call screeners, receive calls reporting the allegations. The calls either come from members of the general public, who may report anonymously, or from mandated reporters, who are required by law to report instances where they suspect abuse and neglect has occurred. Mandated reporters include medical professionals, school staff and youth center or youth recreation workers. The hotline also receives reports from law enforcement officers. By state law, law enforcement agencies and DCFS staff must cross-report allegations of child abuse or neglect they receive to each other, to make sure the allegations are investigated, as necessary, under both criminal law and under the child protection laws guiding DCFS.

When the hotline receives a telephone report, the screener answering the call gets as much information as the reporting party can provide. This includes where and when the alleged abuse or neglect occurred, what happened, the names of the alleged perpetrator and victim, and whether the reporting party believes the child victim is still in danger.

Based on the information obtained, the screener then determines whether an in-person investigation is required, and how quickly that investigation needs to occur. Factors the screener is supposed to consider include whether the child victim can be located, the child's age, whether the incidents described are suggestive of abuse, neglect or exploitation, whether the situation described is one in which imminent danger to the child is likely and other factors. Department procedures list 19 different items to be considered. Under a current pilot program, screeners also complete a decision-tree, which allows them to answer questions based on the information reported regarding the alleged abuse or neglect. The answers to the questions in turn help the screener determine whether an in-person investigation is needed and how quickly.

The screener's options are to require an immediate response, a response within five days, or to "evaluate out" the referral, deciding no additional response is needed. The screener also determines which DCFS office will respond to the referral. For five-day responses and immediate response during regular business hours, response is by one of the Department's eight regional offices, based on the parents' or caregivers' address, or where the victim was found. Responses after 5 p.m. weekdays, and on all weekends and holidays, are provided by the Emergency Response Command Post, which has after-hours staff stationed at hospitals, police stations and other facilities around the County.

Emergency Response Investigation

Once a report of alleged child abuse or neglect is referred by the Hotline to a regional office, or to the Emergency Response Command Post, an Emergency Response (ER) social worker specializing in investigating such allegations is assigned to the referral. These social workers investigate immediate and five-day referrals, and according to the contract with the County social workers union, have a target of investigating referrals involving no more than about 30 children per month, and a maximum caseload of no more than 37 children per month. According to DCFS management, in practice this means an ER worker should receive about 15 referrals per month to investigate.

In the investigative process, the ER worker typically will conduct face-to-face interviews with the victim of abuse or neglect, the victim's parents and/or caregivers and the alleged perpetrator of the abuse or neglect. During such interviews, the worker may also examine the child for cuts, bruises, the condition of the child's clothes and personal hygiene as evidence of abuse or neglect. The worker will also observe the child's living environment for cleanliness, availability of food and other indicators of abuse and neglect, as well as observing the child's interaction with parents.

In addition, the ER worker will conduct in-person or telephone interviews with "collateral" contacts, such as school officials, the child's doctor, neighbors and anyone else believed to have information about the alleged incident and the child's family

situation. Workers may also access the Child Welfare Services/Case Management System for information about previous abuse or neglect allegations regarding the family, as well as criminal information databases. In conducting this background research, the investigating worker may be assisted by Triage Units, staff members who specialize in background research and may be called in on particularly difficult or involved cases to gather the historical data.

Ultimately, the ER worker must determine whether there is credible evidence to believe the reported allegations of abuse or neglect are true. Each allegation referred to the ER worker must be determined to be either:

- **unfounded**, defined as false, inherently improbable, involving an accidental injury or otherwise not constituting abuse or neglect;

- **inconclusive,** defined as having insufficient evidence to determine whether abuse or neglect has occurred; or,

- **substantiated,** defined as constituting, based on some credible evidence, child abuse or neglect.

In addition to determining the truth of the allegations, the ER worker also must assess the present and future risk of child abuse and neglect to the child victim and/or the child's family, based on the investigation, and determine what services should be offered to reduce that risk. Options range from referring the family to parenting classes and other community services, without future oversight by DCFS, to requesting the family to voluntarily accept oversight by the Department, to requesting Superior Court intervention with the family. Both voluntary and court-ordered oversight of the family by DCFS can be in the form of Family Maintenance, where the family receives services while the children remain in the custodial parent's home, or Family Reunification services, in which the child is removed from the home into protective custody and the plan must be completed in order for the child to be returned. In order to seek court intervention, the ER worker must determine that the child has been abused or neglected, or is at risk of being abused and neglected, as defined by Section 300 of the Welfare and Institutions Code, subsections (a) to (j).

When an ER social worker determines that court intervention is necessary with a child and family, and takes the child into protective custody, the worker requests court intervention, which is known as "detaining" the child. The ER worker prepares a detention report, explaining the basis on which the child was detained, the need for continued detention, the available services that could permit the return of the child to the custodial parent or guardian and any services, known as "reasonable efforts," that were provided to the family in order to avoid having to detain the child.

Based on federal funding requirements, the ER worker, within 30 days of the first contact with the family, must complete the investigation and determine what services if any should be provided, and whether the child can safely remain in the custodial parent's home. The services to be provided to the family are typically described in a case plan the ER worker prepares. Following the conclusion of the investigation and preparation of the case plan, the implementation of that plan is overseen by a social worker in the DCFS Bureau of Children and Family Services, to whom the case is transferred.

Intake and Detention Control (IDC)

Once an ER worker decides to detain a child, the detention is reported to the Intake and Detention Control unit. This unit advises the ER worker, based on when the detention occurred, when a petition must be filed with the Superior Court. The petition is a legal document filed by DCFS in Dependency Court, alleging that a child is described by WIC Section 300, and describing the basis for that belief. State law requires the petition to be filed within 48 judicial hours of when a child was taken into protective custody.

Petitions are prepared by the Intake and Detention Control unit, based primarily on the detention report prepared by the ER worker. An IDC social worker receives the detention report and reviews it to determine if the report is sufficient evidence to make a prima facie case, that is, to prove in the absence of contradictory evidence, that abuse or neglect occurred and that a child is at risk. If IDC determines the detention report is insufficient, it may request additional information from the ER worker or conduct additional investigation by telephone. IDC also has the option of rejecting the request for a petition, which would require a child in protective custody to be released.

IDC prepares its own report for the court, recommending whether detention should continue, and making other recommendations regarding visitation, services for parents, etc. This report, along with the petition, and the detention report, is considered by a judge at a detention hearing, held the next judicial day after the petition is filed. The purpose of the hearing is to determine if a prima facie case for continued detention of the child exists. If it does not, the judge can order the child released to the parents.

Dependency Investigation

Assuming that continued detention is ordered by the Court in the detention hearing, the case is transferred from Intake and Detention Control back to the regional office that originally investigated it. The case is assigned to a Dependency Investigator (DI) social worker, who conducts a more thorough investigation of the allegations in the petition, building on the previous work carried out by the Emergency Response worker. The DI worker's investigation may include additional interviews with the child, the alleged abuser, the child's parents or guardians, and additional interviews with new or previous collateral contacts in the case. The purpose of this investigation is to gather sufficient evidence to prove the allegations of the petition, even in the presence of contradicting evidence provided by the child's parent or guardian.

The results of the DI worker's investigation are presented to the Court as a jurisdictional report, which is considered by the court at a jurisdictional hearing, which is supposed to be held within 15 days after the detention hearing. At that hearing, the Court must determine, based on the preponderance of the evidence, whether the child has suffered, or is at risk of suffering, abuse or neglect as described by WIC Section 300. If such a determination is made, the child becomes a dependent of the Court. A subsequent hearing, called a disposition hearing, may be held in conjunction with the jurisdictional hearing, or held within 10 judicial days thereafter. At the disposition hearing, the Court determines, among other things, where the child should be placed, what visitation should be provided to the custodial parent and what services the custodial parent must successfully complete in order for the child to be returned. In making these rulings, the Court may draw on reports prepared by the DI social worker, assessing the ability of other relatives to care temporarily for the child, and on the case plan prepared by the ER worker at the conclusion of the initial investigation of the allegations.

Other Issues

In accordance with Sections 7.45 and 7.46 of the United States General Accounting Office Government Auditing Standards, certain issues identified during an audit are worthy of being brought to the attention of Department management even though a specific finding was not included in the audit report. The following issues are included in the Introduction either because they are issues where evaluation was requested by the Grand Jury, but no audit findings resulted, or because they are issues that either Department management or future grand juries may want to evaluate. Audit staff considered these issues to be not sufficiently significant to warrant a separate finding, determined that these issues were outside the scope of the present study, or was unable to devote sufficient time to complete the full analysis that was required.

The Impact of DCFS Financing on Child Dependency Decisions

As part of this project, audit staff was asked to determine whether there are funding incentives that in some way promote decisions by DCFS staff to remove children from custodial parents. To assess this question, we conducted interviews with Department finance staff and with staff from the California Department of Social Services, as well as reviewing budget and finance documents from the Department, the County Chief Administrative Office, and Federal and State sources.

As described earlier in this section, the majority of funding for DCFS, including the abuse and neglect investigation function, comes from Federal and State sources. Federal funds are provided to carry out requirements of various federal laws, including Titles of the Social Security Acts of 1937 and 1960, the Child Abuse Prevention and Treatment Act, the Adoption and Safe Families Act and others. State funds, which match the federal money, support carrying out sections of the Welfare and Institutions Code related to child abuse and neglect, as previously described in the Introduction, as well as portions of the Health and Safety Code related to licensing of group homes for foster children, foster parent training and related items outside the scope of this study.

The County in turn budgets the funds received in three ways:

- An Administrative Budget, which includes employee salaries and benefits, services and supplies.

- An Assistance Budget, which includes all payments to caregivers, including foster parents, relative caregivers and adoptive families

- A MacLaren Budget for the MacLaren Children's Center, which under the memorandum of understanding between DCFS and other entities that oversee the Center, is supposed to be separated from other Department activities.

Of the three budgets, only the Assistance Budget is dependent on the number of children taken into protective custody. Once a child is detained, DCFS eligibility workers research the child's history and background to determine the types of State and Federal funding to which the child is entitled, and allocate the funding to that child for purposes of paying the caregiver with whom the child resides. The amount of payment for out-of-home care also depends on the child's needs. For example, when a child has special medical care or mental health care needs, the eligibility worker would use CWS/CMS to determine the level and types of payment the child is entitled to, and therefore, the level of payment the caregiver will receive.

Because this funding goes directly to caregivers, and does not fund DCFS administrative or social worker operations, other than those required to process the caregiver payments, we do not believe this funding provides an incentive for child removal. Furthermore, the likelihood of this funding source providing any incentive for

removal decisions is further reduced by the recent reorganization of the Department into several separate bureaus, including a Bureau of Child Protection and a Bureau of Children and Family Services. The latter bureau is responsible for out-of-home care. Therefore, the staff deciding to take a child into protective custody, and the staff determining the funding for out-of-home care associated with that child, are separate.

The focus of our review was the Administrative Budget, which funds staff salaries and benefits and services and supplies, including costs associated with the investigation of child abuse and neglect allegations. The following table shows the amount of that budget for Fiscal Years 2001 and 2002, excluding the County match, for which exact figures were not available, but which was estimated by the Department to represent approximately 13 percent of all funding categories, on average.

Table I.1
DCFS Administrative Budget

Funding Source	**FY 2000-01**	**FY 2001-02**
State Funding	$194,512,813	$205,810,000
Federal Funding	$345,103,852	$327,553,000
Federal-Other	$0	$49,000
Charges for Adoptions Svcs	$498,000	$498,000
Misc. Sources	$1,360,000	$4,166,000
Total	**$541,474,665**	**$538,076,000**

The State allocates Federal and State funds to DCFS annually, based on a number of allocation categories. Child Protection Hotline and Emergency Response funding comes from the Child Welfare Services Basic allocation. According to State funding documents and information provided by State officials, this allocation is determined based on projected caseloads. The projections are based on historical information from the CWS/CMS system on Hotline "assessments," which are the number of referrals alleging abuse and neglect which are evaluated out by Hotline screeners as not requiring an in-person response, and on "dispositions," which are the number of referrals investigated by Emergency Response social workers and closed within 30 days of being referred to Emergency Response staff. This historical workload information is then translated into an estimated staffing requirement using ratios developed by the State. Those ratios are in turn multiplied by an estimated annual cost per position, which determines the DCFS funding allocation from the State.

Based on historical data for calendar year 2001, we calculated that the Department should have been funded for approximately 766 social workers and 109 supervisors in the Bureau of Child Protection. As described earlier in the Introduction, actual bureau

staffing, according to the August 2001 business plan, was 766 social workers and 118 supervisors, close to the numbers that should have been provided based on the State's funding method. This funding system thus relies on the number of reports of alleged abuse and neglect made to DCFS, not on the actions DCFS takes regarding the reports. The number of reports received depends on the public's willingness to take action, and on State law requiring reports to be made by mandated reporters, not on any actions taken by the Department.

Once an annual allocation is made for DCFS by the State, funds are actually distributed on a monthly basis. On a quarterly basis, DCFS submits claims to the State justifying expenditures for each quarter completed. These claims are used to make adjustments to succeeding monthly payments. According to DCFS Finance staff, the quarterly claims are based on two information sources: 1) A "time study" system, which contains quarterly summaries of how social workers spend their time, based on various categories established by the state, and 2) The Countywide Accounting and Purchasing system, which contains information on DCFS actual expenditures.

Because the time study system uses information provided by social workers who investigate abuse and neglect allegations, we reviewed the time-reporting process to determine if it includes incentives for social workers to take children into protective custody. We determined it does not, for the following reasons:

1. As previously discussed, the initial staff allocations the Department receives from the State are provided based in part on cases disposed of by Emergency Response workers within 30 days. How the case is concluded is not a factor, only that it is concluded within the required time period. In the focus group conducted with Emergency Response social workers as part of this study, workers said they were aware of the need to meet the deadline, and attempted to meet it, but that the deadline itself did not influence how they would conclude a particular case.

2. According to DCFS Finance staff, many social workers do not complete the quarterly time study on a timely basis, and must be reminded repeatedly to do so. Workers in our focus group said they viewed the time study as merely another bureaucratic requirement they had to meet, and were not aware of how its results affect Department funding.

3. The categories in which time is reported do not relate to how a particular case is handled, but how a social worker's time is spent. The primary categories are "Emergency Response: Case Management-Protective Services," used for time spent investigating allegations of abuse or neglect, and for providing a family services to avoid taking children into custody; "Emergency Response: Court-Related Activities," used for time spent to prepare court reports; and, Emergency

Response: Foster Care, used for time spent identifying possible caregiver placements for children. Social workers were unaware if one of these categories represented a greater funding value than the others. We found no evidence of a funding difference between the categories. Therefore, there would be no incentive for a social worker to increase time spent in one category versus the others, and therefore, no incentive to treat cases in a particular manner for funding reasons.

4. As previously described, State allocations for Hotline and Emergency Response funding are based on workload ratios for both functions. Those ratios are different, reflecting the much greater time an in-person investigation requires than a decision by a Hotline screener to evaluate out a telephone report. The decisions that impact the allocations are decisions by screeners as to how many reports require an in-person response. From the perspective of a screener, therefore, the funding incentive would be to evaluate out more calls, thereby showing a higher workload for the Hotline, and generating allocations for additional Hotline staffing the future. However, Fiscal Year 2000-01 statistics obtained from DFCS show that about 86.5 percent of referrals screened by the Hotline resulted in an in-person response, which is about the same percentage as in FY 1999-00. This reflects fairly stringent Department policies on which this determination is based, and does not indicate any effort by screeners to make decisions based on funding.

Based on this analysis, we concluded that there is no logical connection that can be made between funding for the Department, and decisions made by social workers whether or not to take children into protective custody.

The Impact of Welfare Reform on Child Dependency

One of the questions the Grand Jury requested audit staff to address was whether federal welfare reform has had any impact on the numbers of children taken into protective custody by DCFS.

Federal welfare reform was enacted via the Personal Responsibility and Work Opportunity Reconciliation Act, signed into law in August 1996, which converted the former Aid to Families with Dependency Children program into a block grant program called Temporary Assistance for Needy Families (TANF). The requirements of that law included:

- States must require at least one adult in a family receiving aid for more than two years to participate in work activities, as defined by the State.

- States were required to reduce grants to recipients that refused to engage in work, as defined by the State.

- States would be penalized for not meeting specific rates of participation by aid recipients in work-related activities.

- A five-year limitation on how long a family can receive federal aid.

California implemented the federal requirements through the CalWORKS program, which provided aid recipients with job training, child care, transportation, substance abuse and mental health services, among others, with the goal of getting aid recipients into the workforce. The State implemented CalWORKS through plans individual counties were required to submit. Los Angeles County submitted its plan in January 1998, and began implementation soon thereafter. In November 1999, the Board of Supervisors approved a new program, Long-Term Family Self Sufficiency, which brought together County staff, private service providers, school districts and other stakeholders in the development of 46 programs, most funded with CalWORKS monies, to promote employment among aid recipients, ensure access to healthcare, support stable housing and other objectives.

Because the five-year limit on receipt of TANF benefits did not commence until the County's implementation of the CalWORKS program in January 1998, it is not clear that there have in fact been families who have lost federal assistance due to the time limits. In fact the County's CalWORKS plan stated that "no family will confront this prospect prior to January 2003."

However, to assess the possible impact of the new laws on DCFS, we looked at several workload measures over time. These included the number of referrals received by the Child Abuse Hotline, the number of referrals referred to in-person investigation, the number of cases assigned to the Intake and Detention Control Unit for preparation of a petition, and the number of petitions actually filed by that unit. We looked at these measures from Fiscal Year 1996-97 through Fiscal Year 2000-01. We found no relation between changes in these measures and the new welfare reform law. For example, the number of referrals received by the Hotline actually fell by about 4 percent from FY 1999-00 to FY 2000-01, while the number of in-person investigations fell even more sharply, nearly 5 percent. An even more dramatic change was observed for cases assigned to Intake and Detention Control, and petitions filed. Cases assigned fell by more than 25 percent from FY 1996-97 to FY 2000-01, from about 21,500 cases to about 16,000, while the number of petitions filed declined by 42 percent, from about 19,000 to only 11,000. Based on these statistics we concluded that no relationship can be shown between the implementation of welfare reform and the activities of DCFS.

DCFS-Probation Department Coordination Issues

As part of this study, audit staff conducted a focus group with 10 Emergency Response social workers. During that focus group, workers generally cited a problem with coordination between DCFS and the Los Angeles County Probation Department that, while outside the scope of this study, we believe would merit further study by the Department or by a future Grand Jury.

Under Welfare and Institutions Code Section 241.1, a joint determination should be made by DCFS and the Probation Department regarding the most appropriate jurisdictional status for children who could be declared dependents of the court under Section 300, due to abuse or neglect, or wards of the court under Sections 601 or 602. Sections 601 describes so-called status offenses, such as a child's failure to obey parents, curfew violations or chronic truancy, that would permit a child to be declared delinquent. Section 602 permits criminal violations by a child, in certain circumstances, to be adjudicated in Juvenile Court rather than trying the perpetrator as an adult.

According to the social workers interviewed, Probation staff have minimal involvement in the joint assessment that is legally required, tending instead to simply adopt the information prepared by social workers. At the same time, social workers said Probation's goal is to shift as many juveniles to dependency status as possible, particularly those with Section 601 offenses. The result, according to the social workers, is that DCFS is forced to serve children who are really delinquent, leading to problems with failed placements, runaways and associated problems.

The comments by the focus group social workers are buttressed by information regarding one of the 67 case files reviewed as part of this study. The case file indicates that DCFS was fined $100 by the Superior Court because of the Court's determination that the report prepared by the Dependency Investigator for the Jurisdictional Hearing on this case was insufficient. According to the case file, at the Detention Hearing the judge assigned to the case ordered the Jurisdictional Report to include a joint evaluation under Section 241.1, because the child at issue was not only the subject of abuse or neglect allegations, but was also facing a Juvenile Court delinquency hearing because of alleged criminal activity. Despite receiving a continuance to prepare the report, because the case was newly assigned to the social worker, the Jurisdictional Report did not include the required joint evaluation, nor did it include the results of the minor's delinquency hearing, resulting in the sanctions. While the case file does not indicate that the report's shortfall resulted from the Probation Department's failure to cooperate, such a result seems plausible, based on the social workers' comments.

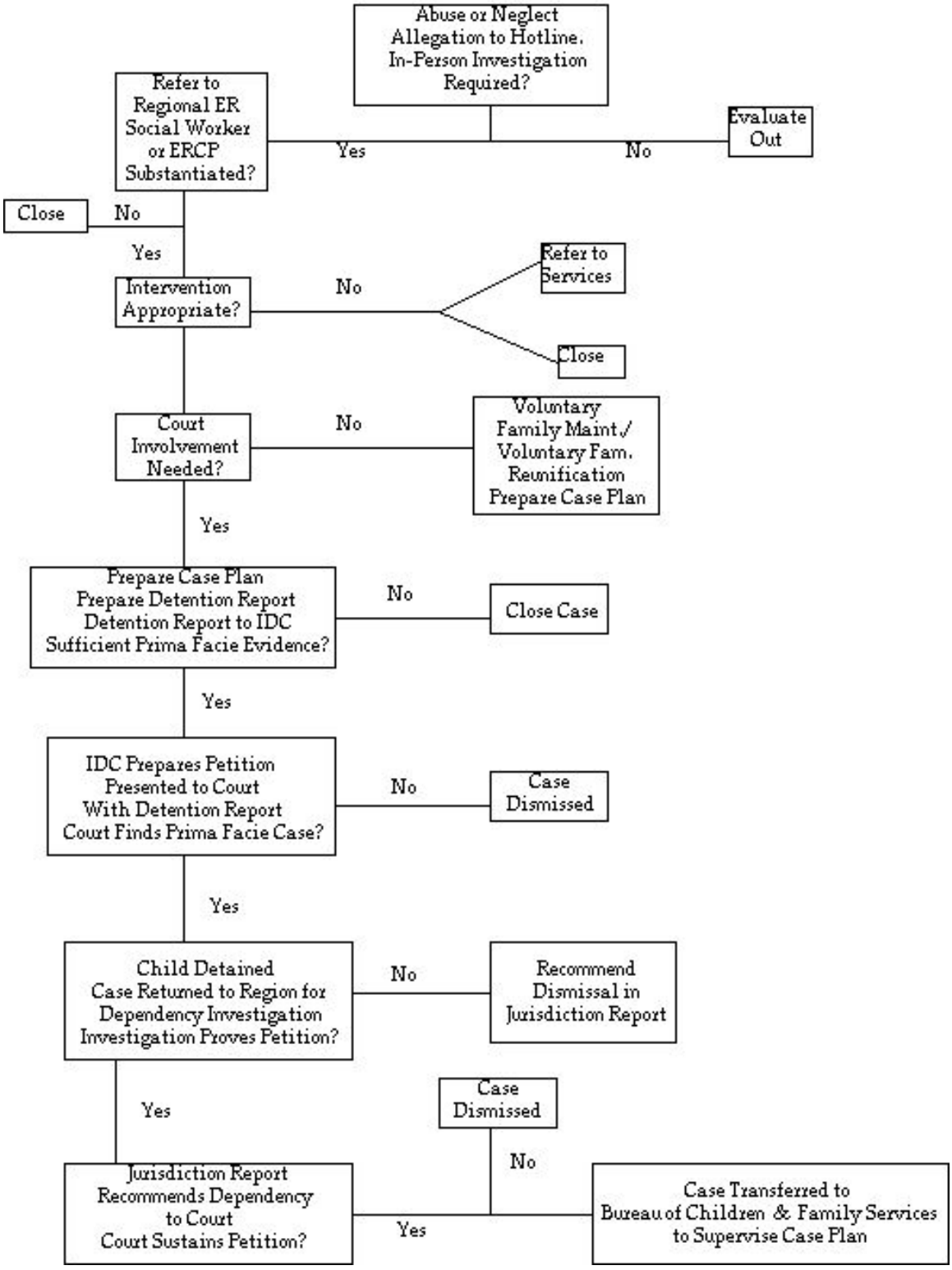
While this issue of Probation Department-DCFS cooperation was outside the scope of the current study, we believe it would be an appropriate topic for further research by DCFS, or by a future Grand Jury. This research should review existing DCFS and

Probation Department procedures for preparing these joint assessments, determine if these procedures are followed in practice, identify problems with this process, and make recommendations for improving this joint function as necessary.

Acknowledgments

We would like to thank the staff of the Department of Children and Family Services for their assistance in completing this study, including providing existing reports and other data, participating in interviews, and providing access to the Department's Child Welfare Services/Case Management System. Without their assistance, our work would have been much more difficult.

Exhibit I.1
Investigative Case Flow Process—Bureau of Child Protection



Section 1: Assessing the Quality of Child Abuse and Neglect Investigations

- **Although the Department of Children and Family Services (DCFS) Bureau of Child Protection includes improving abuse and neglect investigations and reducing the number of children detained in protective custody as key parts of its mission, little analysis of these issues has been developed. Exact numbers of children detained are not available, nor has analysis been conducted of differences in detention rates among different regional offices or different social workers. Even where data are available, they are not being analyzed. For example, data collected by the Intake and Detention Control Unit shows that the percentage of cases in which a petition was requested to be prepared, but was refused by IDC, has fallen by four-fifths in the past 2.5 years, but IDC staff cannot explain why this has occurred. Data available from the Superior Court on petitions that are dismissed also is not analyzed.**

- **Limited analytical capability prevents DCFS from determining whether weaknesses exist in the investigation and risk assessment of child abuse and neglect that could result in children being removed from homes inappropriately, or result in not removing children who are at risk. However, an analysis of 67 cases where contact information was available found that in nearly every case, decisions to take children into custody were based on sufficient collection of evidence, based on the number of contacts made per case.**

- **By conducting similar analyses to that conducted for this study, and by collecting data on case dispositions for regional offices and for individual social workers, DCFS Bureau of Child Protection could identify weaknesses in investigation and risk assessment of child abuse and neglect, biases among social workers, or other problems that result in children being taken into custody inappropriately, or not being removed when they are at risk. Analysis of this data should be assigned to the Quality Assurance Unit in the Bureau, while data collection should be assigned to supervisors and administrators in regional offices and at the Emergency Response Command Post.**

As described in the Introduction to this report, the Bureau of Child Protection in the Department of Children and Family Services is responsible for investigating allegations of child abuse and neglect. According to its mission statement, among the Bureau's goals is "to provide thorough investigations and prompt initial assessments that will maximize child safety through improved child abuse investigations (and to) minimize the number of detentions. . . ." As described in the Introduction, detentions are decisions to take a child into protective custody and to seek to have the child declared a dependent of the Superior Court.

While the mission is to minimize the number of detentions, currently the Bureau has limited information on whether it is accomplishing that goal. For example, the Department's Internet site provides information on the number of referrals received by its Child Abuse Hotline, and the number of referrals where an in-person investigation occurred, but no data on the outcome of the investigations.

Limited statewide data, gathered by the Center for Social Services Research at the University of California at Berkeley, suggest that DCFS' handling of abuse and neglect investigations is not outside statewide norms. The Center has since 1998 collected data from the Child Welfare Services/Case Management system regarding the number of referrals reported to each County and the number of those referrals substantiated, as defined in the Introduction to this report. As described in the Introduction, while substantiation of a child abuse or neglect allegation is not the sole factor in determining that a child should be removed from the home, it is a necessary first step to that decision. The following table reports the percentage of referrals substantiated for the past three calendar years for the 10 largest California counties.

Table 1.1

Comparison of Percentage of Referrals Substantiated
In the 10 Largest California Counties
Calendar Year 1998, 1999 and 2000

County	1998	1999	2000	Three-Year Average
Orange	46.10%	48.34%	46.72%	47.05%
Sacramento	26.61%	25.09%	23.14%	24.95%
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As the table shows, while Los Angeles County is the state's largest county, it is only fifth highest in the percentage of substantiated abuse and neglect allegations, and contrasts markedly, for example, with Orange County, where the percentage of substantiated allegations is more than twice as high.

In terms of Departmental statistics, Department staff reported that data on the number of children taken into protective custody is not specifically tracked.

What is available is data on the number of cases assigned to the Intake and Detention Control Unit (IDC), and the number of actual petitions filed by the unit. IDC represents a key gate-keeping function for the investigation of abuse and neglect cases, and a key check on the quality of the investigations conducted by Emergency Response social workers, because IDC can determine not to prepare a petition in a particular case, if it determines there is not sufficient evidence to do so. This would require the return of the child to the custodial parent, and in our view, represent a situation where the initial removal may not have been appropriate, and alternative resolutions, such as seeking the family's voluntary agreement to receive services, should have been pursued. The following table reports, for the last five fiscal years, the number of child referrals, the number of in-person investigations, the number of cases assigned to Intake and Detention Control, and the number of petitions prepared by that unit.

Table 1.2

Child Abuse and Neglect Referrals, In-Person Investigations
Petition Requests and Petitions Filed, FY 1996-97 to FY 2000-01

Fiscal Year	Referrals	In-Person Investigations	Cases to IDC	Petitions Filed	% Petitions on IDC Cases
1996-97	195,283	147,255	21,499	19,190	89.26%
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As Table 1.1 shows, numbers of referrals, in-person investigations, cases assigned to IDC and petitions filed have all fallen in recent years. Particularly striking, however, is that the number of petitions filed, as a percentage of the number of cases referred to IDC, has declined significantly, from 89 percent to about 69.5 percent, in the past five fiscal years. In other words, while the number of cases referred to IDC dropped, the number of petitions filed dropped even more, a change that cannot be explained solely by the overall reduction in DCFS workload.

The data on cases assigned probably overstates the number of children taken into custody, since some cases may be assigned to IDC for other reasons. On the other hand, data on petitions filed probably slightly overstates the number of children taken into custody, because a petition may be filed regarding a child who is left with their custodial parent, receiving Family Maintenance services under court supervision, as described in the Introduction. However, in a memorandum transmitting data to the Grand Jury on requests for petitions and petitions filed, IDC staff indicated that petition

requests generally represented situations where children were taken into protective custody.

This decline in filing of petitions by IDC is even more stark in statistics kept by IDC itself. These statistics compare only cases assigned for the purpose of preparing a petition to the total petitions filed, and are reported separately for that reason, and because IDC was able to provide only 2.5 years of data. According to this data, the percentage of cases where a petition was requested by a social worker for a child taken into protective custody, but a petition was not filed, was 13.33 percent in Fiscal Year 1999-00, 7.89 percent in FY 2000-01, and only 3.05 percent fir the first six months of FY 2001-02. In other words, the percentage of cases in which IDC determined a petition was not warranted has fallen by more than four-fifths in 2.5 years. Furthermore, IDC reported that of those cases where it declined to prepare a petition, approximately 90 percent in both FY 1999-00 and FY 2000-01 were concluded by returning the child to the custodial parent, with minimal services provided by the ER social worker, or with a referral to community services without further DCFS supervision.

We asked IDC staff who prepared these statistics if any analysis had been conducted as to why the number of petitions not filed had fallen. We were advised that no such analysis had been done. Staff familiar with the numbers speculated that because both requests for petitions as well as the number of petitions filed had fallen, the change reflected decisions by Emergency Response social workers not to detain children in some situations where children were detained before. However, staff could not assess what would cause this change in approach, since IDC had never communicated to Emergency Response staff any concern about the volume of petition requests, or the quality of investigations provided. Also, while IDC conducted training on detention report preparation that could partially account for this change, since detention reports are the main data source used by IDC to prepare petitions, IDC staff said the training occurred between July and October 2001, after significant declines in petitions filed had begun to occur.

Furthermore, IDC staff reported that no analysis is ever conducted on the performance of different regional offices, or individual social workers, as to how often their requests for petitions are rejected, or other outcome measures. Such as regional analysis would help the Bureau of Child Protection to identify inconsistencies in performance by different offices and different social workers, so they could be corrected. We recommend that the Bureau gather this information on performance by regional offices and individual workers from IDC, as well as analyzing the data already gathered by IDC to determine why the changes discussed here have occurred. During the exit conference for this audit, the Department reported that it is developing a request for proposal, in conjunction with the American Public Welfare Association, for an independent research entity to assess the effect of recently developed training programs for Emergency Response social workers and other changes in investigative practices. The Department stated that the decline in the percentage of petition requests rejected by

IDC could be included in that study. We concur with this approach, but recommend that this issue be studied in the first phase of what is expected to be a three-phase project, with the first phase starting in the fall of 2002.

In addition to IDC, the other key gate-keeping function in the investigation of child abuse and neglect is the Superior Court itself. As described in the Introduction, the Court can dismiss the allegations either at the initial Detention Hearing, by finding that no prima facie evidence of abuse or neglect exists, or at the Jurisdictional Hearing, by determining that there is not a preponderance of evidence supporting the allegations of the petition. Information for these two hearings are provided in reports prepared by Emergency Response social workers and Dependency Investigation social workers, respectively. Superior Court staff provided information for the past three fiscal years on the petitions heard and dismissed in Detention and Jurisdiction hearings, as shown in the following table.

Table 1.3

WIC Section 300 Petitions Dismissed by the Superior Court During Detention and Jurisdiction Hearings. Calendar Years 1999, 2000 and 2001

Detention Hearings

Year	Petitions Heard	Petitions Dismissed	Percent Dismissed
1999	10,700	50	0.47%
2000	9,375	62	0.66%
2001	9,092	52	0.57%

Jurisdiction Hearings

Year	Petitions Heard	Petitions Dismissed	Percent Dismissed
1999	23,868	572	2.39%
2000	21,181	737	3.48%
2001	18,837	607	3.22%

As the table illustrates, over the past three years, the percentage of cases dismissed by the Court at either the Detention or Jurisdiction hearing has been very low, and has remained relatively consistent. Detention Hearing dismissals are particularly rare, reflecting the relatively low legal standard that must be met for the Court to order a child to be detained. In providing this data, Court staff advised us that the computer system used to collect the data also provides a coding system that judges can use to indicate why a petition is being dismissed. Unfortunately, Court staff reported that most cases are either not coded, or are coded to indicate that the petition was dismissed "in the interests of justice," without additional detail. This prevents DCFS from using information on these dismissals as a means of reviewing the quality of investigations and reports conducted by Emergency Response and Dependency Investigation social workers. Furthermore, as in the case of the IDC data previously described, no effort is made to gather the information for different regional offices, or for different social workers. DCFS should request that the Court begin using the detailed coding system to report the reasons petitions are dismissed, and also determine if it is possible for the Court to provide this information on a regional and individual social worker basis, so the information may be used to assess social worker performance.

The Bureau of Child Protect Business Plan, issued in August 2001, proposes the development of a 13-person Quality Assurance Unit in the Bureau. According to the plan, the functions of this bureau include reviewing the quality of referrals prepared by Child Abuse Hotline screeners who decide which cases require in-person investigation,

the quality of investigations conducted by the Emergency Response and Dependency Investigation social workers, and the quality of Detention and Jurisdictional reports prepared by the social workers. In addition, a December 2001 letter from the Bureau chief outlining quality assurance programs, provided to audit staff, stated that at that time the Quality Assurance Unit had already collected baseline data on the quality of investigation of selected referrals, and on the quality of the reports prepared. However, the Bureau Chief in the Child Protection Bureau advised audit staff that as yet no reports in these areas had been completed by the unit. He said a planned report on the quality reports prepared by investigators had been delayed, because Bureau staff had concluded that the number of reports examined in the study was insufficient to reach definitive conclusions.

Case File Review

Because data assessing the quality of investigations and the question of whether children are inappropriately taken into protective custody was lacking within the Bureau itself, audit staff conducted an independent analysis. The analysis was based on a review of 67 cases, drawn at random from logs maintained by the Intake and Detention Control Unit (IDC) of all cases in which a petitions was requested to be prepared. The 67 cases were drawn from logs for the months of October and November 2001. Each case represented a request by a social worker in one of the eight regional offices, or in the Emergency Response Command Post, as described in the Introduction to this report, for IDC to prepare a petition on behalf of a child that had been taken into protective custody. Each case also represented a new allegation of abuse or neglect under Welfare and Institutions Code Section 300 that was investigated, as opposed to preparation of subsequent or supplemental petitions, as permitted by State law, for new allegations or changed circumstances regarding an existing case. The sample was divided among cases investigated by two of the eight DCFS regions, Region III, which includes the Belvedere and Metro North offices, and Region VI, which includes the Hawthorne, Century and West Los Angeles offices. These two regions were selected in order to look for regional differences in how cases were handled, and were identified as serving somewhat similar areas in terms of socioeconomic characteristics.

Electronic records in the CWS/CMS system for each case were examined, as was the paper case file for each case. Among the items reviewed for each case were:

- The number of individuals contacted as part of the investigation, and their relation to the family and/or child involved in the allegation.

- The use of decision-making tools by social workers to help make conclusions as to whether a child was at risk of abuse or neglect, and should be taken into protective custody as a result.

- The content of Detention and Jurisdiction reports prepared by social workers.

- Whether there were cases in which a child initially taken into custody by an Emergency Response social worker was subsequently returned to the custodial parent, either because IDC determined that insufficient evidence existing to file a petition, or because the allegations of the petition were dismissed by the Superior Court, either during the prima facie Detention Hearing or the Jurisdictional Hearing described in the Introduction to this report. We would view situations in which a child was removed from the home initially, then subsequently returned, as incidents in which the original removal may not have been appropriate, and alternative resolutions, such as offering the family services on a voluntary basis, should have been considered.

While selected aspects of the case file review will be discussed in other sections of the report, in this our focus is on the social workers' use of sufficient contacts in investigating allegations of abuse or neglect, and on the incidence of child removals by Emergency Response social workers that are subsequently reversed, for the reasons described above.

Use of Collateral Contacts

Contacts are individuals from whom an Emergency Response social worker gathers information to determine whether an abuse or neglect allegation is true, and whether the child that is the subject of the allegation is at risk of further abuse or neglect. In interviews with a focus group of ER social workers, most agree that they would make their initial contact with the person that reported the allegation, if available, followed by the child who was the alleged victim, and then the child's custodial parent.

However, Department policies also emphasize including in the investigation "collateral" contacts, individuals other than those immediately involved in the allegation. Such contacts would include other family relatives, physicians who have treated the child, teachers and other school officials. The importance of such contacts was emphasized in a March 2001 memorandum to social workers, which noted that making such contacts is a requirement of State child welfare regulations. "Information from these interviews can be invaluable when assessing the validity of the reported allegations and determining the disposition of those allegations, as well as in determining if any additional allegations may exist. Information gathered from these interviews may also help the CSW to determine the most appropriate services and case plan goals for the family."

Accordingly, our review included a review, using data from CWS/CMS, of the number of contacts utilized by social workers in our case file sample, excluding the child and the parent. Results of this review are shown in the following table.

Table 1.3

Collateral Contacts in a Sample of 67 Cases Where Children Were Taken Into Protective Custody

Cases With:	**Number of Cases**	**Percentage**
Zero Contacts	3	4.5%
One Contact	22	32.8%
Two Contacts	12	17.9%
Three Contacts	14	20.9%
Four Contacts	10	14.9%
Five Contacts	2	3.0%
Six Contacts	2	3.0%
Seven Contacts	2	3.0%
Total Cases	**67**	**100.0%**
Average Contacts Per Case		**2.4**
Types of Contacts		
Other Relatives	36	
Health Care Officials	33	
Triage Unit	6	
Police	10	
School staff	6	
Other	14	

As the table shows, in only 3 of the 67 cases examined, 4.5 percent, were there no contacts in the investigation beyond the child victim and the custodial parent. The average number of collateral contacts per case was 2.38, with about a third of the cases having one collateral contact, and more than half the cases having two, three or four contacts. There was also little difference between the two regions reviewed, with Region III averaging 2.44 contacts per case, while Region VI average about 2.31. The table also shows that the most common collateral contact was with a family member other than the parent or child, such as a grandparent, an aunt, etc. Also common were contacts with health care officials. This reflects in part the high percentage of abuse and neglect allegations reported to DCFS by hospital officials as a result of instances in which a newborn child, the mother or both are determined to have narcotics in their system as a result of blood tests. Under State law, such positive blood tests require the hospital to conduct its own assessment of whether the child is at a health risk. If a risk is determined to exist, the hospital is then required to report the incident to DCFS for investigation of possible child neglect. However, the case files we reviewed indicated

that Emergency Response social workers typically obtained information from the mother about drug use, or information about the mother's intoxication from hospital staff or other collateral contacts in determining that allegations were substantiated.

Based on this case file analysis, we believe that social worker investigations of child abuse and neglect allegations are based on sufficient evidence, as reflected by the use of collateral contacts as part of those investigations.

Subsequent Child Releases

As part of this case file review, we also reviewed the Detention Hearing reports and the court orders reflecting the results of Detention Hearings in each case, as well as the Jurisdiction Reports, and court orders reflecting the results of Jurisdiction Hearings. These items were reviewed to determine how often children taken into protective custody by an ER social worker are subsequently released, either voluntarily by the Department, or as a result of a court's dismissal of the petition at either the Detention Hearing or Jurisdiction Hearing. As discussed previously, such instances may reflect cases in which the original decision to take a child into protective custody was not proper, and other alternatives should have been considered.

Our case file review identified six cases of the 67 reviewed, or 9 percent of the sample, in which a child was taken into protective custody by a social worker, but was subsequently released back to the custodial parent. At face value, this appears to be a high percentage of cases where the initial removal may not have been appropriate.

However, the detailed review of these case files also showed that in nearly every case, there were specific appropriate reasons for the initial custody and subsequent release. In four of the six cases, detention was based on allegations of abuse pertaining to only one of two custodial parents. According to the case file data, in these cases, the perpetrator agreed to leave the home, and the children were then released to the other parent. In other words sufficient evidence existed for the original detention.

The remaining two cases involved situations where children were taken into protective custody and then released to the parents by Court order. In one case this occurred at the Detention Hearing, while in the other it occurred at the Jurisdiction Hearing. However, in both cases, subsequent investigation, either related to the original referral or to a subsequent referral, resulted in these children being re-detained, and declared dependents of the Court, within a few weeks of being released back to the custodial parent. Based on the information contained in the case files, it appears that the original protective custody decisions were appropriate, and should not have been overturned by the Court.

Based on this review, we do not believe that any of the 67 cases reviewed for this study represented instances where children were inappropriately removed from their homes. This suggests protective custody decisions generally made by social workers are appropriate. However, we would emphasize that our review represents a small sample of cases, drawn from only two DCFS regions, and limited by the short timeframe required for this study. A larger sample, drawn from all regions, and from the Emergency Response Command Post, may result in different conclusions. The Department should develop a regular program of such case reviews, carried out by the Quality Assurance Unit. During the exit conference, the Department reported that it expects, starting in June 2002, to have the Quality Assurance Unit review a random sample of approximately 400 referrals per month that were investigated by regional offices and the three shifts of the Emergency Response Command Post. The sample would be equally divided among referrals where allegations of abuse or neglect were determined to be unfounded, inconclusive and substantiated, and would assess the quality of the investigation that was conducted and the reports that were prepared.

CONCLUSION

The Department of Children and Family Services has developed relatively little data assessing the quality of investigations of child abuse and neglect, and whether children are inappropriately removed from their custodial parents. Even where data has been developed, no analysis has occurred. For example, the percentage of cases in which the Intake and Detention Control Unit is requested to prepare a petition for a child that has been detained, but declines to do so because of insufficient evidence, has fallen substantially since FY 1996-97, particularly in the past 2.5 years, but no review has been made as to why this occurred. However, an analysis conducted by audit staff of 67 cases where children were detained in October and November 2001 found no evidence that any of the detentions were improper, and showed that multiple collateral contacts occurred as part of the investigation in most cases.

RECOMMENDATIONS

It is recommended that the Department of Children and Family Services:

1.1 Research, as part of the first phase of an upcoming study of the effect of recent investigative training and other changes in investigative practices, why the percentage of petitions not filed for insufficient evidence by the Intake and Detention Control Unit has fallen in recent years, and develop a system to gather data on IDC rejections by regional offices and by individual social workers, in order to identify systematic performance differences that require correction. (Recommendation 133)

1.2 Request that the Superior Court, if possible, provide information on a regional office and individual social worker basis on petitions dismissed at Detention Hearings or Jurisdictional Hearings, in order to identify performance differences that require correction. (Recommendation 134)

1.3 Conduct periodic case file reviews, similar to that reported in this section, to assess the quality of investigations conducted by Emergency Response and Dependency Investigation social workers. These reviews should include samples of cases in each region. Such reviews should be conducted by the Department's Quality Assurance Unit. According to the Department, a monthly system of such reviews will begin in June 2002. (Recommendation 135)

SAVINGS AND BENEFITS

Implementing the recommendations in this section would provide the Department better information on the adequacy of child abuse and neglect investigations, identifying differences in practices in different regions and among different workers, to help ensure that investigations are conducted properly, and that children are not removed from their homes inappropriately. More detailed reporting by the Intake and Detention Control Unit would probably require expanded data entry time by clerical staff, at an unknown cost. More detailed data reporting by the Superior Court also would have additional costs. The file reviews recommended should be included as part of the workload of the new Quality Assurance Unit, and should not have additional costs.

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requests generally represented situations where children were taken into protective custody.

This decline in filing of petitions by IDC is even more stark in statistics kept by IDC itself. These statistics compare only cases assigned for the purpose of preparing a petition to the total petitions filed, and are reported separately for that reason, and because IDC was able to provide only 2.5 years of data. According to this data, the percentage of cases where a petition was requested by a social worker for a child taken into protective custody, but a petition was not filed, was 13.33 percent in Fiscal Year 1999-00, 7.89 percent in FY 2000-01, and only 3.05 percent fir the first six months of FY 2001-02. In other words, the percentage of cases in which IDC determined a petition was not warranted has fallen by more than four-fifths in 2.5 years. Furthermore, IDC reported that of those cases where it declined to prepare a petition, approximately 90 percent in both FY 1999-00 and FY 2000-01 were concluded by returning the child to the custodial parent, with minimal services provided by the ER social worker, or with a referral to community services without further DCFS supervision.

We asked IDC staff who prepared these statistics if any analysis had been conducted as to why the number of petitions not filed had fallen. We were advised that no such analysis had been done. Staff familiar with the numbers speculated that because both requests for petitions as well as the number of petitions filed had fallen, the change reflected decisions by Emergency Response social workers not to detain children in some situations where children were detained before. However, staff could not assess what would cause this change in approach, since IDC had never communicated to Emergency Response staff any concern about the volume of petition requests, or the quality of investigations provided. Also, while IDC conducted training on detention report preparation that could partially account for this change, since detention reports are the main data source used by IDC to prepare petitions, IDC staff said the training occurred between July and October 2001, after significant declines in petitions filed had begun to occur.

Furthermore, IDC staff reported that no analysis is ever conducted on the performance of different regional offices, or individual social workers, as to how often their requests for petitions are rejected, or other outcome measures. Such as regional analysis would help the Bureau of Child Protection to identify inconsistencies in performance by different offices and different social workers, so they could be corrected. We recommend that the Bureau gather this information on performance by regional offices and individual workers from IDC, as well as analyzing the data already gathered by IDC to determine why the changes discussed here have occurred. During the exit conference for this audit, the Department reported that it is developing a request for proposal, in conjunction with the American Public Welfare Association, for an independent research entity to assess the effect of recently developed training programs for Emergency Response social workers and other changes in investigative practices. The Department stated that the decline in the percentage of petition requests rejected by

IDC could be included in that study. We concur with this approach, but recommend that this issue be studied in the first phase of what is expected to be a three-phase project, with the first phase starting in the fall of 2002.

In addition to IDC, the other key gate-keeping function in the investigation of child abuse and neglect is the Superior Court itself. As described in the Introduction, the Court can dismiss the allegations either at the initial Detention Hearing, by finding that no prima facie evidence of abuse or neglect exists, or at the Jurisdictional Hearing, by determining that there is not a preponderance of evidence supporting the allegations of the petition. Information for these two hearings are provided in reports prepared by Emergency Response social workers and Dependency Investigation social workers, respectively. Superior Court staff provided information for the past three fiscal years on the petitions heard and dismissed in Detention and Jurisdiction hearings, as shown in the following table.

Table 1.3

WIC Section 300 Petitions Dismissed by the Superior Court During Detention and Jurisdiction Hearings. Calendar Years 1999, 2000 and 2001

Detention Hearings

Year	Petitions Heard	Petitions Dismissed	Percent Dismissed
1999	10,700	50	0.47%
2000	9,375	62	0.66%
2001	9,092	52	0.57%

Jurisdiction Hearings

Year	Petitions Heard	Petitions Dismissed	Percent Dismissed
1999	23,868	572	2.39%
2000	21,181	737	3.48%
2001	18,837	607	3.22%

As the table illustrates, over the past three years, the percentage of cases dismissed by the Court at either the Detention or Jurisdiction hearing has been very low, and has remained relatively consistent. Detention Hearing dismissals are particularly rare, reflecting the relatively low legal standard that must be met for the Court to order a child to be detained. In providing this data, Court staff advised us that the computer system used to collect the data also provides a coding system that judges can use to indicate why a petition is being dismissed. Unfortunately, Court staff reported that most cases are either not coded, or are coded to indicate that the petition was dismissed "in the interests of justice," without additional detail. This prevents DCFS from using information on these dismissals as a means of reviewing the quality of investigations and reports conducted by Emergency Response and Dependency Investigation social workers. Furthermore, as in the case of the IDC data previously described, no effort is made to gather the information for different regional offices, or for different social workers. DCFS should request that the Court begin using the detailed coding system to report the reasons petitions are dismissed, and also determine if it is possible for the Court to provide this information on a regional and individual social worker basis, so the information may be used to assess social worker performance.

The Bureau of Child Protect Business Plan, issued in August 2001, proposes the development of a 13-person Quality Assurance Unit in the Bureau. According to the plan, the functions of this bureau include reviewing the quality of referrals prepared by Child Abuse Hotline screeners who decide which cases require in-person investigation,

the quality of investigations conducted by the Emergency Response and Dependency Investigation social workers, and the quality of Detention and Jurisdictional reports prepared by the social workers. In addition, a December 2001 letter from the Bureau chief outlining quality assurance programs, provided to audit staff, stated that at that time the Quality Assurance Unit had already collected baseline data on the quality of investigation of selected referrals, and on the quality of the reports prepared. However, the Bureau Chief in the Child Protection Bureau advised audit staff that as yet no reports in these areas had been completed by the unit. He said a planned report on the quality reports prepared by investigators had been delayed, because Bureau staff had concluded that the number of reports examined in the study was insufficient to reach definitive conclusions.

Case File Review

Because data assessing the quality of investigations and the question of whether children are inappropriately taken into protective custody was lacking within the Bureau itself, audit staff conducted an independent analysis. The analysis was based on a review of 67 cases, drawn at random from logs maintained by the Intake and Detention Control Unit (IDC) of all cases in which a petitions was requested to be prepared. The 67 cases were drawn from logs for the months of October and November 2001. Each case represented a request by a social worker in one of the eight regional offices, or in the Emergency Response Command Post, as described in the Introduction to this report, for IDC to prepare a petition on behalf of a child that had been taken into protective custody. Each case also represented a new allegation of abuse or neglect under Welfare and Institutions Code Section 300 that was investigated, as opposed to preparation of subsequent or supplemental petitions, as permitted by State law, for new allegations or changed circumstances regarding an existing case. The sample was divided among cases investigated by two of the eight DCFS regions, Region III, which includes the Belvedere and Metro North offices, and Region VI, which includes the Hawthorne, Century and West Los Angeles offices. These two regions were selected in order to look for regional differences in how cases were handled, and were identified as serving somewhat similar areas in terms of socioeconomic characteristics.

Electronic records in the CWS/CMS system for each case were examined, as was the paper case file for each case. Among the items reviewed for each case were:

- The number of individuals contacted as part of the investigation, and their relation to the family and/or child involved in the allegation.

- The use of decision-making tools by social workers to help make conclusions as to whether a child was at risk of abuse or neglect, and should be taken into protective custody as a result.

- The content of Detention and Jurisdiction reports prepared by social workers.

- Whether there were cases in which a child initially taken into custody by an Emergency Response social worker was subsequently returned to the custodial parent, either because IDC determined that insufficient evidence existing to file a petition, or because the allegations of the petition were dismissed by the Superior Court, either during the prima facie Detention Hearing or the Jurisdictional Hearing described in the Introduction to this report. We would view situations in which a child was removed from the home initially, then subsequently returned, as incidents in which the original removal may not have been appropriate, and alternative resolutions, such as offering the family services on a voluntary basis, should have been considered.

While selected aspects of the case file review will be discussed in other sections of the report, in this our focus is on the social workers' use of sufficient contacts in investigating allegations of abuse or neglect, and on the incidence of child removals by Emergency Response social workers that are subsequently reversed, for the reasons described above.

Use of Collateral Contacts

Contacts are individuals from whom an Emergency Response social worker gathers information to determine whether an abuse or neglect allegation is true, and whether the child that is the subject of the allegation is at risk of further abuse or neglect. In interviews with a focus group of ER social workers, most agree that they would make their initial contact with the person that reported the allegation, if available, followed by the child who was the alleged victim, and then the child's custodial parent.

However, Department policies also emphasize including in the investigation "collateral" contacts, individuals other than those immediately involved in the allegation. Such contacts would include other family relatives, physicians who have treated the child, teachers and other school officials. The importance of such contacts was emphasized in a March 2001 memorandum to social workers, which noted that making such contacts is a requirement of State child welfare regulations. "Information from these interviews can be invaluable when assessing the validity of the reported allegations and determining the disposition of those allegations, as well as in determining if any additional allegations may exist. Information gathered from these interviews may also help the CSW to determine the most appropriate services and case plan goals for the family."

Accordingly, our review included a review, using data from CWS/CMS, of the number of contacts utilized by social workers in our case file sample, excluding the child and the parent. Results of this review are shown in the following table.

Table 1.3

Collateral Contacts in a Sample of 67 Cases Where Children Were Taken Into Protective Custody

Cases With:	**Number of Cases**	**Percentage**
Zero Contacts	3	4.5%
One Contact	22	32.8%
Two Contacts	12	17.9%
Three Contacts	14	20.9%
Four Contacts	10	14.9%
Five Contacts	2	3.0%
Six Contacts	2	3.0%
Seven Contacts	2	3.0%
Total Cases	**67**	**100.0%**
Average Contacts Per Case		**2.4**
Types of Contacts		
Other Relatives	36	
Health Care Officials	33	
Triage Unit	6	
Police	10	
School staff	6	
Other	14	

As the table shows, in only 3 of the 67 cases examined, 4.5 percent, were there no contacts in the investigation beyond the child victim and the custodial parent. The average number of collateral contacts per case was 2.38, with about a third of the cases having one collateral contact, and more than half the cases having two, three or four contacts. There was also little difference between the two regions reviewed, with Region III averaging 2.44 contacts per case, while Region VI average about 2.31. The table also shows that the most common collateral contact was with a family member other than the parent or child, such as a grandparent, an aunt, etc. Also common were contacts with health care officials. This reflects in part the high percentage of abuse and neglect allegations reported to DCFS by hospital officials as a result of instances in which a newborn child, the mother or both are determined to have narcotics in their system as a result of blood tests. Under State law, such positive blood tests require the hospital to conduct its own assessment of whether the child is at a health risk. If a risk is determined to exist, the hospital is then required to report the incident to DCFS for investigation of possible child neglect. However, the case files we reviewed indicated

that Emergency Response social workers typically obtained information from the mother about drug use, or information about the mother's intoxication from hospital staff or other collateral contacts in determining that allegations were substantiated.

Based on this case file analysis, we believe that social worker investigations of child abuse and neglect allegations are based on sufficient evidence, as reflected by the use of collateral contacts as part of those investigations.

Subsequent Child Releases

As part of this case file review, we also reviewed the Detention Hearing reports and the court orders reflecting the results of Detention Hearings in each case, as well as the Jurisdiction Reports, and court orders reflecting the results of Jurisdiction Hearings. These items were reviewed to determine how often children taken into protective custody by an ER social worker are subsequently released, either voluntarily by the Department, or as a result of a court's dismissal of the petition at either the Detention Hearing or Jurisdiction Hearing. As discussed previously, such instances may reflect cases in which the original decision to take a child into protective custody was not proper, and other alternatives should have been considered.

Our case file review identified six cases of the 67 reviewed, or 9 percent of the sample, in which a child was taken into protective custody by a social worker, but was subsequently released back to the custodial parent. At face value, this appears to be a high percentage of cases where the initial removal may not have been appropriate.

However, the detailed review of these case files also showed that in nearly every case, there were specific appropriate reasons for the initial custody and subsequent release. In four of the six cases, detention was based on allegations of abuse pertaining to only one of two custodial parents. According to the case file data, in these cases, the perpetrator agreed to leave the home, and the children were then released to the other parent. In other words sufficient evidence existed for the original detention.

The remaining two cases involved situations where children were taken into protective custody and then released to the parents by Court order. In one case this occurred at the Detention Hearing, while in the other it occurred at the Jurisdiction Hearing. However, in both cases, subsequent investigation, either related to the original referral or to a subsequent referral, resulted in these children being re-detained, and declared dependents of the Court, within a few weeks of being released back to the custodial parent. Based on the information contained in the case files, it appears that the original protective custody decisions were appropriate, and should not have been overturned by the Court.

Based on this review, we do not believe that any of the 67 cases reviewed for this study represented instances where children were inappropriately removed from their homes. This suggests protective custody decisions generally made by social workers are appropriate. However, we would emphasize that our review represents a small sample of cases, drawn from only two DCFS regions, and limited by the short timeframe required for this study. A larger sample, drawn from all regions, and from the Emergency Response Command Post, may result in different conclusions. The Department should develop a regular program of such case reviews, carried out by the Quality Assurance Unit. During the exit conference, the Department reported that it expects, starting in June 2002, to have the Quality Assurance Unit review a random sample of approximately 400 referrals per month that were investigated by regional offices and the three shifts of the Emergency Response Command Post. The sample would be equally divided among referrals where allegations of abuse or neglect were determined to be unfounded, inconclusive and substantiated, and would assess the quality of the investigation that was conducted and the reports that were prepared.

CONCLUSION

The Department of Children and Family Services has developed relatively little data assessing the quality of investigations of child abuse and neglect, and whether children are inappropriately removed from their custodial parents. Even where data has been developed, no analysis has occurred. For example, the percentage of cases in which the Intake and Detention Control Unit is requested to prepare a petition for a child that has been detained, but declines to do so because of insufficient evidence, has fallen substantially since FY 1996-97, particularly in the past 2.5 years, but no review has been made as to why this occurred. However, an analysis conducted by audit staff of 67 cases where children were detained in October and November 2001 found no evidence that any of the detentions were improper, and showed that multiple collateral contacts occurred as part of the investigation in most cases.

RECOMMENDATIONS

It is recommended that the Department of Children and Family Services:

1.1 Research, as part of the first phase of an upcoming study of the effect of recent investigative training and other changes in investigative practices, why the percentage of petitions not filed for insufficient evidence by the Intake and Detention Control Unit has fallen in recent years, and develop a system to gather data on IDC rejections by regional offices and by individual social workers, in order to identify systematic performance differences that require correction. (Recommendation 133)

1.2 Request that the Superior Court, if possible, provide information on a regional office and individual social worker basis on petitions dismissed at Detention Hearings or Jurisdictional Hearings, in order to identify performance differences that require correction. (Recommendation 134)

1.3 Conduct periodic case file reviews, similar to that reported in this section, to assess the quality of investigations conducted by Emergency Response and Dependency Investigation social workers. These reviews should include samples of cases in each region. Such reviews should be conducted by the Department's Quality Assurance Unit. According to the Department, a monthly system of such reviews will begin in June 2002. (Recommendation 135)

SAVINGS AND BENEFITS

Implementing the recommendations in this section would provide the Department better information on the adequacy of child abuse and neglect investigations, identifying differences in practices in different regions and among different workers, to help ensure that investigations are conducted properly, and that children are not removed from their homes inappropriately. More detailed reporting by the Intake and Detention Control Unit would probably require expanded data entry time by clerical staff, at an unknown cost. More detailed data reporting by the Superior Court also would have additional costs. The file reviews recommended should be included as part of the workload of the new Quality Assurance Unit, and should not have additional costs.

Section 2: Documentation of Reasonable Efforts

- **State law requires social workers, before taking a child into protective custody, to determine whether there are any reasonable services available that could be provided to eliminate the need to remove the child from the custodial parent, guardian or caretaker. The basis for this determination must be documented, in order for the Superior Court to determine whether such "reasonable efforts," were provided. A review of 67 case files identified 16, or 23.9 percent in which information on reasonable efforts was not reported. In another 13 cases, the lack of reasonable efforts was explained by the child being detained from an "emergent situation," an exception to the legal requirement that was available at the time of the case files reviewed, but was eliminated by the State as of January 1, 2002. Even when reasonable efforts were documented, no detail was provided in court reports on the services given, nor did case files generally provide information on pre-detention services.**

- **This lack of detailed reporting does not follow the department's own reporting procedures regarding preparation of Detention Reports, based on materials from training that occurred during 2001, and does not provide sufficient documentation that reasonable efforts were in fact provided. In addition, interviews with social workers indicated that this problem may reflect limited information available on service resources, particularly to social workers at the Emergency Response Command Post.**

- **By requiring more detailed reporting by social workers on what services were available to eliminate the need to take children into protective custody, the Department will ensure that the requirements to make reasonable efforts, and to document making them, are met. The Department also should develop a field guide to service resources for Emergency Response Command Post (ERCP) social workers, based on service information provided by the various regional offices. This would ensure that ERCP workers make realistic recommendations to services, based on the resources that are actually available.**

As described in the Introduction, an Emergency Response social worker's investigation of abuse or neglect allegations must first determine if the allegations are true. Based on that determination, they then determine if the child has suffered, or if there is a substantial risk that the child will suffer abuse or neglect, and what actions should be taken to eliminate that risk. Specifically, Welfare and Institutions Code (WIC) Section 306(b) requires that the social worker consider, before taking a child into protective custody, whether the child can remain safely in his or her home. The factors that must be considered in making that determination include:

> "Whether there are any reasonable services available to the worker which, if provided to the minor's parent, guardian, caretaker or to the minor, would eliminate the need to remove the minor from the custody of his or her parent, guardian or caretaker."

In the case of an Emergency Response social worker investigating allegations of abuse and neglect and determining how to address them, these services would be provided during the period between the social worker's first response to the allegation of abuse and neglect, and the time when the worker decides how the allegations should be disposed of. As described in the Introduction, that period is normally a maximum of 30 days. By that time, the Emergency Response social worker must either refer the case for court action, obtain a voluntary agreement from the parent or guardian to receive services under the Department's supervision, or close the case with no further DCFS supervision.

In order to ensure that the assessment required by Section 306(b) occurs, WIC Section 319 requires a court to "make a determination as to whether reasonable efforts were made to prevent or eliminate the need for removal of the child from his or her home . . . whether there are available services that would prevent the need for further detention."

This determination is made based on information provided by the social worker as part of the Detention Hearing, described in the Introduction, where a judge determines if there is reasonable evidence, absent contradictory evidence, that removal of the child from the custodial parent or guardian was proper, and should continue. According to Section 319, services to be considered in determining whether reasonable efforts were provided include:

- Case management.
- Emergency shelter care.
- Emergency in-home caretakers.
- Out-of-home respite care.
- Teaching and demonstrating homemakers.
- Parenting training.
- Transportation.
- Other services authorized by the State Department of Social Services.

- Whether a referral to Medi-Cal, general assistance and emergency medical care, food stamps and CalWORKs programs would have prevented the need for further detention.

As part of the review of 67 case files described in the Introduction and in Section 1, audit staff reviewed detention reports to determine whether information on reasonable efforts were provided.

We found that in 16 of the 67 files reviewed, 23.9 percent, reasonable efforts were not discussed in the Detention Report. Although the standard report format available on the Child Welfare Services/Case Management System includes a section of the report to describe the services provided, that section was left blank. WIC Section 319 indicates that the court's assessment of reasonable efforts should be "referencing the social worker's report or other evidence relied upon." Since none of the files reviewed indicated a court determination that reasonable efforts were lacking, presumably social worker testimony or some other basis was used for the determination. Nevertheless, the absence of this information in these reports represents poor documentation of a legal requirement.

In another 13 of the 67 files reviewed, 19.4 percent, the reasonable efforts section of the Detention Report was completed by indicating that reasonable efforts could not be provided due to the "emergent nature" of the situation. This statement corresponds to WIC Section 319, as it was in effect at the time these Detention Reports were prepared, which requires a judge to determine that the lack of services prior to detention was reasonable, when the first contact with the family was in an emergency situation where the child could not safely remain at home, even with services being provided. Statutes of 2001, Chapter 653 (A.B. 1695) removed this language, effective January 1, 2002, although our review of statutes and case law suggests that a sufficiently dire situation would still permit a social worker to take a child into custody without providing reasonable efforts prior to the removal. In any event, the Detention Reports reviewed here do not provide additional detail tying the statement back to the actual facts of the case, showing the nature of the emergency that the social worker encountered. This detail should be provided, in order to clearly show why steps could not be taken to eliminate the need to take a child into protective custody. During the exit conference for this audit, the Department noted that it had not received specific advice from County Counsel as to whether this change in the law requires a change in the content of Detention Reports. The Department also stated its belief that there is sufficient evidence elsewhere in such reports showing the nature of the emergency so that the additional explanation recommended here in the reasonable efforts section is not necessary. We respectfully disagree, believing that the additional explanation would make the basis for these decisions clearer to parents and their attorneys, and to the Court. We also recommend that the Department consult with County Counsel regarding any change in reporting requirements necessary due to the amendments to WIC Section 319.

Finally, even in the 38 case files where a Detention Report included information on reasonable efforts, the information provided was nearly always cursory in nature. In only one case file was a detailed description made of the services provided. In all other cases, the information on reasonable efforts was simply a recitation of one or more of the categories of services in Section 319, as described earlier in this section. This method of reporting reasonable efforts appears to come from a version of the Detention Report developed in 1998, in which reasonable efforts were described by checking one or more boxes reflecting the various categories reported in Section 319. This report version is still included in Department procedures for writing a Detention Report, even though it was not used for any of the Detention Reports audit staff reviewed.

In fact, the cursory description of reasonable efforts reflected in most of the case files audit staff reviewed is much different than the description reflected in materials for training on Detention Reports conducted in 2001. The Intake and Detention Control Unit provided this training to all Bureau of Child Protection staff between July and October 2001. Training materials for that packet include a sample Detention Report. That sample included a detailed description of services provided that would constitute reasonable efforts. Because the sample case for training was one where both custodial parents were absent, the description included efforts to locate them. Based on their absence, the report concluded that it could not be shown that the children could remain safely with one parent, with the other parent leaving the home, nor could it be shown that services could be provided allowing the children to remain with the custodial parents.

Because information provided in Detention Reports regarding reasonable efforts was so cursory, we also reviewed the case files for other evidence that services had been provided, separate from the Detention Report. This review found that in 30 of the 67 case files reviewed, 44.8 percent, there was documentation of services being provided prior to a child being taken into protective custody. Usually, this evidence consisted of documentation of services provided through a referral that occurred prior to the incident that caused the current detention. In another 17 cases, 25.4 percent, evidence was provided of services being offered, but only after a child had already been taken into protective custody. This evidence was usually copies of forms signed by custodial parents acknowledging the receipt of lists of service providers for parenting classes, drug and alcohol testing and counseling and other services. Finally, in 20 of the 67 cases, 29.8 percent, there was no evidence of services being provided. In these cases, the case file reflected no activities by the social worker other than those required to investigate the abuse and neglect allegations.

As indicated earlier in this section, statute and case law suggests that it is permissible to offer services constituting reasonable efforts to a family after a child has been taken into protective custody, if the circumstances requiring protective custody are sufficiently

serious. However, in order to make such a showing, we believe more detailed information about the reasonable efforts made, or the mitigating factors preventing them, should be provided than was provided in the Detention Reports audit staff reviewed.

Furthermore, one of the types of services that constitute reasonable efforts under WIC Section 319, called case management, is not defined in the statute, and is poorly defined in State regulations. Chapter 31-002 of the Manual of Policies and Procedures, Child Welfare Services, defines case management as "a service funded activity performed by the social worker which includes assessing the child's/family's needs, developing the case plan, monitoring progress in achieving case plan objectives, and ensuring that all services specified in the space plan are provided." Portions of this definition referring to the execution of the case plan are not helpful, since the reasonable efforts required by Section 319 would typically occur before or at the same time as a case plan is prepared. References to needs assessment or case plan development could include activities that principally relate to the investigation of the allegations. However, such a result would be incongruous, in that it would permit virtually any case investigated by an Emergency Response social worker to meet the reasonable effort standard. Again, the clearest way to show the standard has been met is to provide greater detail on the steps taken than was provided in the Detention Reports reviewed by audit staff.

Based on the variance we found between the training social workers were supposed to receive and the actual content of Detention Reports, and based on the lack of other service information in the case files, we recommend that the Department take additional steps to ensure reasonable efforts are properly documented. The Department should send out a memorandum to all Emergency Response social workers advising them that the description of reasonable efforts should include a detailed description of the services provided, not just references to the categories of services listed in WIC Section 319. The Department should also consult with County Counsel as to what the typical content of such descriptions should include. Supervisors also should be advised not to approve Detention Reports that do not have this level of detail. In addition, Intake and Detention Control staff should be reviewing the description of reasonable efforts in the report. Where insufficient information is provided, IDC should obtain additional detail from the Emergency Response social worker to include in IDC's own report to the court.

IDC should also prepare a monthly report for distribution to Department management and to all regional offices, indicating the number and percentage, by regional office of Detention Reports that failed to adequately describe the reasonable efforts provided. IDC also should retain copies of the reports that fail to meet the standard, for review by regional office managers and supervisors who want to pinpoint which social workers are the source of problems in this area. This reporting system should remain in force for about one year after this recommendation is implemented. After that, the Department

could switch to a system of spot checking a sample of detention reports, assuming the incidence of problems is sufficiently small.

Insight into reasons for the sketchy detail regarding reasonable efforts was provided in interviews with Emergency Response social workers for this audit. Workers generally acknowledged a conflict in their role, in that they are supposed to both investigate reports of abuse and neglect, but also provide services to the families they are investigating, which can be difficult when workloads get too high. Some of the workers said in recent months they have felt more pressure to emphasize investigation at the expense of providing services, because the referrals they receive are more serious, while others still felt they were emphasizing providing services to maintain children in their homes.

Workers also said that a major difficulty in referring clients to services was the cost. While parenting classes, for example, are inexpensive, costing participants about $1 per session, some domestic violence programs cost $25 per session, which may be too much for some clients. Drug counseling and testing also may be too expensive, workers said. Workers also generally agreed that they have little contact with other county agencies, such as the Department of Health Services or the Mental Health Department, in identifying County services to help clients. Workers noted that while DCFS has begun providing a System of Care program to bring together various County services to help keep children in their homes, the program has relatively few openings, and is only available to children who are unable to be placed in standard foster homes, with a relative or in most group homes, because of health or behavioral problems.

During the exit conference for this audit, the Department stated its agreement with these assessments by social workers regarding barriers to providing services. The Department noted that it is pursuing a new model for responding to allegations of abuse and neglect, that would completely separate investigation of allegations from identifying and providing services, from the start of the investigation. This model, described in the Child Protection Bureau's August 2001 Business Plan, also includes development of multidisciplinary assessment teams to assess the needs of children entering foster care or relative placements. The teams would include social workers, County health and mental health staff and community-based service providers. While pilot projects to test the viability of assessment teams are slated to begin in Fall 2002, widespread implementation of the new model is the subject of ongoing negotiations with the social workers' union, with no timetable yet established. Until this new model is established, the recommendations of this section would provide incentive for social workers to make sure reasonable efforts are provided, based on the requirement for more detailed reporting of the steps that were taken.

Finally, workers generally indicated that their primarily resource for identifying services to which clients can be referred are lists developed in each regional office of

service resources in the area the region serves. Workers said they occasionally supplement this localized information with data from a hard-copy Countywide guide that was developed several years ago, and from Countywide information provided via the Department's internal Intranet site, LAKids. However, workers who used the Countywide information indicated that it was dated in some respects.

This issue of information on available services also generated fairly significant criticism by workers in regional offices of the Emergency Response Command Post, which investigates allegations of abuse and neglect that are reported to the Department after regular business hours, on weekends and on holidays. Regional ER social workers said ERCP workers often will refer families to services, without actually providing the family information on where to get the services needed. This creates a problem for the regional worker who may be assigned the case on a follow-up basis, and ends up trying to find services for a particular family that may not in fact be available near where the family lives.

Related to this problem, regional ER workers also said that in some cases, ERCP investigators will persuade a family to accept services when the family really doesn't want them. When a regional worker contacts the family on a follow-up basis to arrange for the services, the family then refuses them. This may require the regional worker to reassess the family and detain a child on a case that was supposedly resolved, adding to the regional worker's caseload.

Because workers agreed these problems may reflect a lack of knowledge about available services by ERCP staff, who answer referrals in areas of the County with which they are not familiar, we recommend that a service handbook be developed for ERCP workers to carry in the field. This handbook should be comprised of information provided by each regional office on the services available to families in its area. This would permit the ERCP worker to refer clients to specific service providers in the area where the family lives, reducing conflicts among ERCP staff, regional ER staff and the clients.

CONCLUSION

State law requires social workers investigating allegations of abuse and neglect to determine whether there are services available that could permit them to safely remain in their custodial parent's or guardian's home. Such "reasonable efforts" must also be documented in reports to the courts. However, a review of a sample of 67 DCFS case files found that documentation was not provided to the court in about 24 percent of the files. Even where documentation was provided, court reports had no detail about the services provided, despite recent training on the level of detail that should be provided. Furthermore, about 30 percent of the case files lacked evidence that clients were referred to services, regardless of the information provided to the court. A focus group of social workers found one source of these problems may be a lack of information by

Emergency Response Command Post workers as to services available in various areas of the County.

RECOMMENDATIONS

It is recommended that the Department of Children and Family Services:

2.1 Consult with County Counsel on the content that should be included in describing reasonable efforts made to eliminate the need to take children into protective custody. (Recommendation 136)

2.2 Issue a memo to all Emergency Response social workers emphasizing the need to include in Detention Reports detailed descriptions of the reasonable efforts provided to families investigated for abuse and neglect allegations, or more detailed information on the emergent circumstances of the case that made it infeasible to provide such reasonable efforts. (Recommendation 137)

2.3 Require the Intake and Detention Control Unit to track whether reports contain a properly detailed description of reasonable efforts, preparing a monthly report indicating the percentage, by regional office, which do not meet the new standards. This monthly reporting should be provided for one year after Recommendation 2.2 is implemented, and may be reduced to spot-checking Detention Reports thereafter, assuming the incidence of violations is sufficiently low. (Recommendation 138)

2.4 Develop a services handbook for Emergency Response Command Post workers to carry, utilizing information on available service resources that has already been developed by regional offices. (Recommendation 139)

SAVINGS AND BENEFITS

Implementing the recommendations in this section would ensure that reasonable efforts are provided to families investigated for abuse and neglect allegations, and that those efforts are properly reported to the Superior Court. This would require a slight amount of additional time for Detention Report preparation by Emergency Response social workers. The monitoring of the recommendations by Intake and Detention Control staff would also require some slight additional time in statistical reporting. The recommendations would also ensure that Emergency Response Command Post staff has current information on services available in various areas of the County. These recommendations should have minimal costs, essentially limited to costs of reproducing the services handbook for ERCP staff.

Section 3: Use of Assessment Tools and Procedures

- **To assist social workers in assessing allegations of child abuse and neglect, the Department of Children and Family Services (DCFS) requires use of "assessment tools" as a means of analyzing the information collected by Child Abuse Hotline screeners, and by Emergency Response social workers investigating in person. The Department also has an extensive procedures manual. However, a review of 68 case files, and interviews with social workers, found these tools are not always properly used. For example, in only 42.6 percent of the case files reviewed was the Assessment Guide properly filled out by the Emergency Response social worker. Furthermore, the tool used by most Emergency Response workers does not reflect the most current research in the field. Also, while the Department's procedures manual is extensive, there are gaps in some areas, and the manual is not formatted in a manner that would be easy for ER workers to refer to in the field.**

- **As a result, the Department is not assured that the goals of the assessment tools and procedures, which are to ensure consistency and accuracy in investigations, are met.**

- **By fully implementing the Structured Decision-Making system now in use as a pilot project, and providing social workers with research showing its effectiveness, the Department will have greater assurance that the tools are used as intended, and that their purpose is accomplished. The Department should complete missing portions of its Procedure Guide for social workers and use portions of the Guide to develop a procedural manual specifically for use by Emergency Response and Dependency Investigator social workers, similar to that previously developed for the Child Abuse Hotline, so that these workers can carry with them only the procedures that directly relate to their function.**

In investigating allegations of child abuse and neglect, social workers gather information from a variety of contacts, and must then draw conclusions based on the information collected. These conclusions include whether or not the allegations are true, whether a child that is the subject of the allegations remains at risk for abuse or neglect, and what action is needed to eliminate that risk. Potential actions can include providing services to the child's family with the child remaining in the home, with the family participating on a voluntary or court-ordered basis, or removing the child from the home, and providing services the family must successfully complete before the child is returned.

In order to assist social workers with this decision-making process, the Department of Children and Family Services (DCFS) requires the use of assessment or screening tools

as a way of analyzing the information collected. As defined by one academic study of this subject:

> Departments of Social Services are increasingly being challenged to determine which cases reported to them are at highest risk and most in need of services. One response to this challenge involves the development of screening procedures that distinguish levels of risk and need among cases that come to the attention of Child Welfare Services. . . . The employment of effective screening procedures . . . can help not only to reduce disruptive legal intervention into families in situations when it is unwarranted, but also to insure procedural fairness—one-element of which involves consistency in the treatment received by similar cases. The systematic use of screening guidelines would help to promote consistency among decisions made by individual workers and among counties; it would also aid new workers in the field and offer workers and the state some degree of protection in an era of increased litigation.[1]

DCFS currently uses three assessment tools:

- Child Abuse Hotline Screeners use a series of decision-trees that are part of the Structured Decision-Making system developed by the Children's Research Center, a non-profit group. The decision-trees ask a series of questions that the screener must answer for each report of alleged child abuse and neglect reported. The questions differ depending on the type of abuse or neglect being alleged, and the answers to the questions help the screener determine whether an immediate investigation is needed, whether an investigation is needed within five days or whether the referral can be closed without further action. The decision trees are provided as a software program on the computers that screeners use.

- Most Emergency Response social workers are required to fill out a one-page form, called the Assessment Guide, to document the risk factors a child faces, as part of making the determination whether the child should be taken into protective custody. Separate guides are provided for drug-exposed infants and for other types of abuse and neglect. The standard guide includes four risk factors relating to the child, and 16 risk factors related to the parent, guardian or caretaker. The social worker rates the factor as representing a low, intermediate or high risk for each child assessed, then provides a written analysis at the bottom of the form indicating which risk factors are the most critical and what actions were taken to reduce the risk to the child and or/family. Department procedures require the form to be completed "at all critical decision points throughout the life of the case," including when an Emergency Response social worker concludes an investigation into abuse or neglect

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allegations, when a child is taken into protective custody, when a case plan for services is prepared or updated, and when services are ended.

- Emergency Response social workers in Region IV, as a pilot project, are using materials from the Structured Decision-Making (SDM) system as an alternative to the Assessment. The SDM system uses a series of questionnaires, including a safety assessment, a family risk assessment and a family strengths and needs assessment, to analyze the risk to the child and family and identify what steps should be taken to reduce it.

Because of the importance of these tools to the child abuse and neglect investigation process, audit staff assessed when and how each tool was used in our case file review of 68 cases.

Use of Hotline Decision Trees

According to documents provided by DCFS, use of this tool began in late December 1999, and the tool is supposed to be used in all reports where an immediate in-person response or a five-day response is recommended (as opposed to cases that are evaluated out, as described in the Introduction. However, our review found this did not always occur. Of 66 cases where the use of the decision-trees could be assessed, the tree was not completed nine times, or 13.6 percent. This was somewhat higher than the 9.7 percent non-completion rate identified during a recent report by the Children's Research Center assessing overall use of SDM in the DCFS pilot project between January 1 and June 30, 2001. Neither this report nor our review could determine why the tool was not used as required. We recommend that when the tool is not used, the screener narrative prepared for each telephone report that is received by a screener should indicate that the tool was not used and the reason why.

Use of Assessment Guides

Use of the assessment tool provided to Emergency Response social workers is extremely important, because of the grave responsibility they bear, which includes the authority to remove a child from the parent or guardian into protective custody. According to social workers interviewed in a focus group, this power extends even to allegations of child abuse and neglect, such as physical abuse or sexual abuse, where legal authority for removal is actually vested under the Welfare and Institutions Code in law enforcement. While the focus group generally agreed they do call in police when required by the code, they also agreed that police typically are following their instructions in taking children into protective custody.

Unfortunately, the 68 case files reviewed by audit staff present a very spotty picture regarding use of this assessment tool. Results of this analysis are displayed in the following table.

Table 3.1

Use of Assessment Guide in a Sample of 68 Case Files

Use of Assessment Guide	Number of Cases	Percentage of Cases
Completed, Not Dated	2	2.9%
Missing	8	11.8%
Completed, But Not for This Detention	8	11.8%
Completed After Child Detained	21	30.9%
Subtotal	39	57.4%
Assessment Guide Properly Complete	29	42.6%
Totals	**68**	**100.0%**

As the table illustrates, in nearly 60 percent of the case files reviewed, the Assessment Guide was not completed as Department procedures require. Perhaps most disturbing was the approximately 23 percent of the cases in which the Guide was missing, either because we could not find it in the file at all, or because the Guide we found was not for the particular child detention analyzed for this study, but for a prior incident. Considering that Department procedures require the Guide to be completed "at all critical decision points throughout the life of the case," we believe this shortfall in current practice to be a serious one.

For many social workers the Assessment Guide is not in practice used as a guide or to assist their decision-making, but is simply a form they are required to fill out. Many social workers appear to have filled it out after they had decided what steps to take in disposing of the allegations. This approach is clearly reflected in the high percentage of Assessment Guides in the sample that were filled out, according to the dates included on the forms, one or more days after children were actually taken into protective custody, based on the date when the social worker contacted the Intake and Detention Control Unit to request a petition. Among the 21 instances in which the Guide was completed after the fact, the delay ranged from one day to 20 days after a child was actually taken into protective custody.

Social workers stated that one reason they do not make use of the Assessment Guide is that it is difficult to use. For example, workers said they were often not sure how to complete the section of the Guide where risk factors associated with the parent or caretaker are assessed, in situations where there were two parents, only one of whom is a perpetrator. Some workers said they will complete separate forms on each parent in that instance.

Inconsistent use of assessment tools is not a problem that is unique to Los Angeles County. For example, a 1997 study of use of assessment tools by Emergency Response social workers in Alameda County, examining both cases referred for court intervention and those closed without it, found that in 28 percent of the court-referred cases studied, social workers did not fill out the tool.[2] Interviews with social workers in that study revealed similar comments to those made in the focus group, that the tools were used primarily to document decisions made based on the social worker's knowledge and experience, and confusion about how elements of the tools are supposed to be interpreted.

Based on the findings of our case file review, it is apparent that additional training may be needed to encourage Emergency Response social workers to use the Assessment Guide as it is designed, or to clarify how it is to be used. Alternatively, the Department is also considering switching to a new form of decision-making tool, the Structured-Decision-Making (SDM) system.

As described earlier in this section, SDM is being used by Emergency Response social workers on a pilot basis in the Department's Region IV. Final conclusions have not yet been reached as to whether SDM is a preferable system to the Assessment Guide for DCFS to use. However, research elsewhere suggests that SDM promotes improved decision-making by social workers.

For example, a 1998 study, funded by the National Center of Child Abuse and Neglect, compared the reliability of the SDM system with an assessment system used in Washington state, and with the California Family Assessment Factor Analysis, the system from which the Assessment Guide is derived. The Washington and California systems, according to the study, are "consensus based," in that they were developed to reflect the judgment of expert social workers, based on their experience, intuition and interviewing skills, as to the key case characteristics that should be assessed to determine risk to the child. By contrast, the SDM system is an "actuarial" system, developed based on research, using many cases over long periods of time that identified specific factors associated with the risk of abuse or neglect to a child. Which factors are present, and the number of factors present, determine the level of risk, and therefore, what action the social worker must take. The SDM system was found to be significantly more reliable, in that multiple social workers using it to evaluate the same test case came up with the same result more often than when the Washington and California systems were used.[3]

Another study, summarizing research on SDM-type assessment systems in Michigan, Georgia and California, found that the system generated consistent risk level ratings

[2] Ibid., pp. xv.
[3] Children's Research Center, Child Abuse and Neglect: Improving Consistency in Decision Making, 1998, pp. 12-24.

among Caucasian, African-American and Hispanic families, so that similar percentages of families in each group were rated as low, moderate and high for risk of abuse or neglect. That study concluded that: "Data presented here demonstrate that proper use of actuarial risk assessment could well reduce over-representation of minority families in the child welfare system."[4]

The difference between these systems is that where the Assessment Guide requires a social worker to determine whether each of the various factors present for the family represent a low, intermediate or high risk, and to weight the presence of the various factors and their risk levels against each other, the SDM system identifies factors whose presence indicates a risk. The more factors present, the higher the risk, as reflected in a point score calculated once the social worker completes the assessment forms. The uncertainties of the Assessment Guide were clearly reflected in our case sample. While in one case where a child was removed, the Assessment Guide indicated one factor at intermediate risk, and the remaining factors at low risk, other cases reflected Assessment Guides showing multiple high-risk factors. There did not seem to be a consistent relationship between the information entered in the Assessment Guide, and the decision to remove a child from their custodial home. While Department policies state that, "The Assessment Guide/Matrix is used as a guide; it is not a substitute for CSW judgment," such wide variations in the information provided via the tool raise questions as to its usefulness.

Unfortunately, the potentially greater utility of the SDM system reflected in research results was not endorsed by social workers in our focus group. Those familiar with the system stated they did not believe it was superior to the Assessment Guide, but simply represented additional paperwork to be completed. However, while the system requires more forms than the one-page Assessment Guide, we believe it may be easier for social workers to use, because it does not require the social worker to independently determine whether particular factors represent a high, moderate or low risk for a child or family. Those factors are determined automatically using a point system, based on the answers the worker provides on the various forms.

In its Business Plan issued in August 2001, the Bureau of Child Protection indicated that among the upcoming changes planned was full implementation of the Structured Decision-Making system in the Bureau. We would endorse this goal. In addition, we recommend that DCFS, as part of training on the system, present the existing research data on the system, indicating its greater utility than the Assessment Guide and other methods, to social workers, as a way of getting them to endorse and actively use the new system.

[4] Baird, Christopher; Ereth, Janice; and, Wagner, Dennis. Research-Based Risk Assessment: Adding Equity to CPS Decision Making. Children's Research Center, June 1999, pp. 23.

Use of Department Procedures Manuals

In addition to the assessment tools discussed previously in this section, the other resource Emergency Response and Child Abuse Hotline social workers have to guide their work is procedure manuals developed by the Department.

As part of this study, we reviewed individual procedure manuals developed for the Child Abuse Hotline and for the Intake and Detention Control Unit, as well as the Department's Procedure Guide, its main manual. As part of its effort to communicate more effectively with child welfare stakeholders and the general public, the Department has taken the laudable step of posting the Procedure Guide on its Internet site, along with a message acknowledging that some parts of the manual may be outdated or internally contradictory, and that a major revision was expected to be completed by January 2002. During the exit conference for this audit, the Department reported that as a result of the new model for investigating allegations of abuse and neglect and providing services discussed in Section 2, additional policies are expected to be developed.

Our review found the Procedure Guide to be highly detailed, providing detailed guidelines for most situations a social worker is likely to encounter. Examples include:

- Specific procedures advising Emergency Response social workers that they must respond to any Immediate Response referral by 5 p.m. of the day the Hotline received the referral, or by the end of shift for after-hours, weekend or holiday referrals received by the Emergency Response Command Post.

- Procedures describing a step-by-step process for contacting the relevant parties in any abuse or neglect investigation, including the reporting party, the child, the family members, etc.

- A procedure on Observation Techniques that cautions social workers to consider alternative explanations when attempting to infer evidence of abuse or neglect from observed behaviors, including consideration of cultural factors that may affect a child's avoidance of physical contact with a parent.

- A procedure describing in detail the process of interviewing a child, including steps to take to ascertain whether the child can discern the difference between the truth and a lie, and that lying is wrong.

- A 62-page Allegation Guide describing in detail physical indicators of specific types of abuse and neglect.

- Individual procedures for assessing substance abuse by a parent, prenatal exposure of infants to drugs or alcohol, child exploitation, domestic violence, physical abuse, failure to thrive, parental incapacity, Shaken Infant Syndrome and Fetal Alcohol Syndrome.

- A 122-page glossary of key terms in child protective services.

Our review also identified selected areas where the Procedure Guide could be improved. First, a number of procedures cross-referenced within the Guide are missing, including a description of Dependency Court hearings, procedures for assessing sexual abuse and interviewing protocols. Not mentioned in the document is a procedure for assessing emotional abuse, which we recommend be added.

There appears to be a particular need for additional procedures regarding interviews, based on comments of social workers in interviews conducted by audit staff. Workers indicated they were particularly confused about how to convince collateral contacts, such as family members other than the parents and children, neighbors, school officials, etc., to provide information about a family, without compromising the confidentiality of the investigation which must be maintained by State law. Workers were clearly uncertain about how much they could reveal about why they were requesting information from these contacts, and tended to err on the side of not explaining the situation at all, which made it difficult to convince these contacts to assist. Workers also said that the training they have received in investigative interviewing techniques, primarily from law enforcement representatives, tended to emphasize quasi-prosecutorial techniques such as use of deception or verbal threats, which the social workers found inappropriate or ineffective in the child welfare context.

A memorandum sent to all workers by Department management in March 2001 on the topic of collateral interviews indicated that a work group had been established to develop more specific guidance on approaching collateral contacts. However, there is no indication that this group ever completed its work. We recommend that the Department complete interviewing protocols for inclusion in the Procedure Guide as soon as possible. The protocols should address how much, if any information a social worker can reveal to a collateral contact to explain the need for assistance. They should also provide more general interview suggestions as to how to put a subject at ease and keep them talking, such as the use of open-ended questions, repeating the interviewee's words back to them as an inducement to further explanation, and the proper use of expectant silences to get people to elaborate.

Second, our review of the Department's Internet site shows that the For Your Information memoranda issued to social workers as clarifications or limited updates of items in the Procedure Guide were not complete, based on cross-references to memoranda that are still in force, but were not available on the web site. For example,

FYI 97-16, Questioning the Health Care Provider About Abuse, references FYI 96-29, Diagnostic Imaging: A Requirement for the Medical Examination for Physical Abuse and Severe Neglect Cases. However, the latter item was not available on the web site. Since the site contains selected memoranda dating from as long ago as 1995, we recommend that the Department review all bulletins issued from that year to the present, and make sure that those remaining in force are posted to the website for use by its staff and the public. We also recommend that the Department discontinue the use of these supplemental memoranda to amend existing procedures or create new ones. Arguably, the information in the two memos cited above might more appropriately be dealt with in a formal procedure describing the use of medical resources in abuse and neglect investigations. Instead, the FYI memos should be used to provide information about internal Department issues, such as changes in time reporting requirements or vacation request procedures. They could also be used to provide information related to but not part of Department procedures. For example, some procedures refer to requirements of case law. As new cases come to the Department's attention that social workers should be aware of, the FYI bulletins would be a good way to provide short descriptions of the requirements of such rulings for social workers to review and retain for reference purposes.

Finally, social workers in the focus group indicated that they occasionally refer to Department procedures, but not routinely. Several stated that the number of policies creates confusion, and the workload leaves little time to refer back to reference documents. One problem may be the lack of a manual geared specifically to the needs of Emergency Response and Dependency Investigation social workers. A specific manual has not been developed for these groups, as it has for the Hotline and for the Intake and Detention Control Unit. We recommend that such a document be developed. It could start with the Assessment Flow Chart, a document in the Procedure Guide that describes the investigation process, and should also include the Allegation Guide, the procedures on assessing various types of abuse and neglect, existing policies related to investigative contacts and the interview process, search warrant procedures, and the as yet undeveloped interview protocols previously discussed. The goal would be to provide a binder's worth of material that a social worker could carry with them in a vehicle, containing the key information a worker might need to refer to while investigating in the field.

CONCLUSION

To assist social workers in assessing allegations of child abuse and neglect, the Department of Children and Family Services (DCFS) requires use of "assessment tools" to determine which Child Abuse Hotline referrals should receive in-person investigation, and how soon, and to determine the risk to children who are the subject of in-person investigations, to decide whether to remove a child from the custodial parent. However, a review of 68 case files, and interviews with social workers, found

these tools are not always used, or are used in a perfunctory manner. For example in only 42.6 percent of the cases examined was the Assessment Guide used by Emergency Response social workers properly completed. Furthermore, this tool does not reflect the most current research in the field. Also, while the Department's procedures manual is extensive, there are gaps in some areas, and the manual is not formatted in a manner that would be easy for ER workers to refer to in the field. As a result, the Department is not assured that the goals of the assessment tools and procedures, which are to ensure consistency and accuracy in investigations, are met.

RECOMMENDATIONS

It is recommended that the Department of Children and Family Services:

3.1 Require Child Abuse Hotline social workers, as part of the screener narrative prepared for each report received, to indicate whether the Structured Decision-Making decision tree was completed, and if it was not, why it was not used. (Recommendation 140)

3.2 Implement the Structured Decision-Making system in place of the existing Assessment Guide completed by Emergency Response social workers, and present to social workers, as part of training in the new system, information showing its greater reliability. (Recommendation 141)

3.3 Complete the revision of the Department Procedure Guide by including the missing elements described in this section, particularly interviewing protocols. . (Recommendation 142)

3.4 Update the Department website regarding the For Your Information memoranda issued by management to staff, including copies of all currently active memos on the site. Revise the use of the FYI communication, limiting it to internal Department issues and updates to employees on relevant case law, for example. (Recommendation 143)

3. 5 Develop a procedure manual for Emergency Response and Dependency Investigation social workers, using parts of the Procedure Guide, similar to the manual already developed for Child Abuse Hotline staff. . (Recommendation 144)

SAVINGS AND BENEFITS

Use of the Structured Decision-making system by Emergency Response social workers should result in more reliable decision-making, based on existing research on the system, if training induces workers to use the system as intended. While the system provides more forms for social workers to fill out, it may be easier to use, because of the

point system used to determine whether the factors present for a particular child or family create a high, medium or low risk of abuse or neglect. Completing the revision of the Department's Procedure Guide, and creating a procedure manual for Emergency Response and Dependency Investigation social workers, can be completed with minimal additional cost in staff time and reproduction costs, and will provide a useful information source for these workers, providing only the key procedures related to their function.

Section 3: Use of Assessment Tools and Procedures

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- **By fully implementing the Structured Decision-Making system now in use as a pilot project, and providing social workers with research showing its effectiveness, the Department will have greater assurance that the tools are used as intended, and that their purpose is accomplished. The Department should complete missing portions of its Procedure Guide for social workers and use portions of the Guide to develop a procedural manual specifically for use by Emergency Response and Dependency Investigator social workers, similar to that previously developed for the Child Abuse Hotline, so that these workers can carry with them only the procedures that directly relate to their function.**

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Inconsistent use of assessment tools is not a problem that is unique to Los Angeles County. For example, a 1997 study of use of assessment tools by Emergency Response social workers in Alameda County, examining both cases referred for court intervention and those closed without it, found that in 28 percent of the court-referred cases studied, social workers did not fill out the tool.[2] Interviews with social workers in that study revealed similar comments to those made in the focus group, that the tools were used primarily to document decisions made based on the social worker's knowledge and experience, and confusion about how elements of the tools are supposed to be interpreted.

Based on the findings of our case file review, it is apparent that additional training may be needed to encourage Emergency Response social workers to use the Assessment Guide as it is designed, or to clarify how it is to be used. Alternatively, the Department is also considering switching to a new form of decision-making tool, the Structured-Decision-Making (SDM) system.

As described earlier in this section, SDM is being used by Emergency Response social workers on a pilot basis in the Department's Region IV. Final conclusions have not yet been reached as to whether SDM is a preferable system to the Assessment Guide for DCFS to use. However, research elsewhere suggests that SDM promotes improved decision-making by social workers.

For example, a 1998 study, funded by the National Center of Child Abuse and Neglect, compared the reliability of the SDM system with an assessment system used in Washington state, and with the California Family Assessment Factor Analysis, the system from which the Assessment Guide is derived. The Washington and California systems, according to the study, are "consensus based," in that they were developed to reflect the judgment of expert social workers, based on their experience, intuition and interviewing skills, as to the key case characteristics that should be assessed to determine risk to the child. By contrast, the SDM system is an "actuarial" system, developed based on research, using many cases over long periods of time that identified specific factors associated with the risk of abuse or neglect to a child. Which factors are present, and the number of factors present, determine the level of risk, and therefore, what action the social worker must take. The SDM system was found to be significantly more reliable, in that multiple social workers using it to evaluate the same test case came up with the same result more often than when the Washington and California systems were used.[3]

Another study, summarizing research on SDM-type assessment systems in Michigan, Georgia and California, found that the system generated consistent risk level ratings

[2] Ibid., pp. xv.
[3] Children's Research Center, Child Abuse and Neglect: Improving Consistency in Decision Making, 1998, pp. 12-24.

among Caucasian, African-American and Hispanic families, so that similar percentages of families in each group were rated as low, moderate and high for risk of abuse or neglect. That study concluded that: "Data presented here demonstrate that proper use of actuarial risk assessment could well reduce over-representation of minority families in the child welfare system."[4]

The difference between these systems is that where the Assessment Guide requires a social worker to determine whether each of the various factors present for the family represent a low, intermediate or high risk, and to weight the presence of the various factors and their risk levels against each other, the SDM system identifies factors whose presence indicates a risk. The more factors present, the higher the risk, as reflected in a point score calculated once the social worker completes the assessment forms. The uncertainties of the Assessment Guide were clearly reflected in our case sample. While in one case where a child was removed, the Assessment Guide indicated one factor at intermediate risk, and the remaining factors at low risk, other cases reflected Assessment Guides showing multiple high-risk factors. There did not seem to be a consistent relationship between the information entered in the Assessment Guide, and the decision to remove a child from their custodial home. While Department policies state that, "The Assessment Guide/Matrix is used as a guide; it is not a substitute for CSW judgment," such wide variations in the information provided via the tool raise questions as to its usefulness.

Unfortunately, the potentially greater utility of the SDM system reflected in research results was not endorsed by social workers in our focus group. Those familiar with the system stated they did not believe it was superior to the Assessment Guide, but simply represented additional paperwork to be completed. However, while the system requires more forms than the one-page Assessment Guide, we believe it may be easier for social workers to use, because it does not require the social worker to independently determine whether particular factors represent a high, moderate or low risk for a child or family. Those factors are determined automatically using a point system, based on the answers the worker provides on the various forms.

In its Business Plan issued in August 2001, the Bureau of Child Protection indicated that among the upcoming changes planned was full implementation of the Structured Decision-Making system in the Bureau. We would endorse this goal. In addition, we recommend that DCFS, as part of training on the system, present the existing research data on the system, indicating its greater utility than the Assessment Guide and other methods, to social workers, as a way of getting them to endorse and actively use the new system.

[4] Baird, Christopher; Ereth, Janice; and, Wagner, Dennis. Research-Based Risk Assessment: Adding Equity to CPS Decision Making. Children's Research Center, June 1999, pp. 23.

Use of Department Procedures Manuals

In addition to the assessment tools discussed previously in this section, the other resource Emergency Response and Child Abuse Hotline social workers have to guide their work is procedure manuals developed by the Department.

As part of this study, we reviewed individual procedure manuals developed for the Child Abuse Hotline and for the Intake and Detention Control Unit, as well as the Department's Procedure Guide, its main manual. As part of its effort to communicate more effectively with child welfare stakeholders and the general public, the Department has taken the laudable step of posting the Procedure Guide on its Internet site, along with a message acknowledging that some parts of the manual may be outdated or internally contradictory, and that a major revision was expected to be completed by January 2002. During the exit conference for this audit, the Department reported that as a result of the new model for investigating allegations of abuse and neglect and providing services discussed in Section 2, additional policies are expected to be developed.

Our review found the Procedure Guide to be highly detailed, providing detailed guidelines for most situations a social worker is likely to encounter. Examples include:

- Specific procedures advising Emergency Response social workers that they must respond to any Immediate Response referral by 5 p.m. of the day the Hotline received the referral, or by the end of shift for after-hours, weekend or holiday referrals received by the Emergency Response Command Post.

- Procedures describing a step-by-step process for contacting the relevant parties in any abuse or neglect investigation, including the reporting party, the child, the family members, etc.

- A procedure on Observation Techniques that cautions social workers to consider alternative explanations when attempting to infer evidence of abuse or neglect from observed behaviors, including consideration of cultural factors that may affect a child's avoidance of physical contact with a parent.

- A procedure describing in detail the process of interviewing a child, including steps to take to ascertain whether the child can discern the difference between the truth and a lie, and that lying is wrong.

- A 62-page Allegation Guide describing in detail physical indicators of specific types of abuse and neglect.

- Individual procedures for assessing substance abuse by a parent, prenatal exposure of infants to drugs or alcohol, child exploitation, domestic violence, physical abuse, failure to thrive, parental incapacity, Shaken Infant Syndrome and Fetal Alcohol Syndrome.

- A 122-page glossary of key terms in child protective services.

Our review also identified selected areas where the Procedure Guide could be improved. First, a number of procedures cross-referenced within the Guide are missing, including a description of Dependency Court hearings, procedures for assessing sexual abuse and interviewing protocols. Not mentioned in the document is a procedure for assessing emotional abuse, which we recommend be added.

There appears to be a particular need for additional procedures regarding interviews, based on comments of social workers in interviews conducted by audit staff. Workers indicated they were particularly confused about how to convince collateral contacts, such as family members other than the parents and children, neighbors, school officials, etc., to provide information about a family, without compromising the confidentiality of the investigation which must be maintained by State law. Workers were clearly uncertain about how much they could reveal about why they were requesting information from these contacts, and tended to err on the side of not explaining the situation at all, which made it difficult to convince these contacts to assist. Workers also said that the training they have received in investigative interviewing techniques, primarily from law enforcement representatives, tended to emphasize quasi-prosecutorial techniques such as use of deception or verbal threats, which the social workers found inappropriate or ineffective in the child welfare context.

A memorandum sent to all workers by Department management in March 2001 on the topic of collateral interviews indicated that a work group had been established to develop more specific guidance on approaching collateral contacts. However, there is no indication that this group ever completed its work. We recommend that the Department complete interviewing protocols for inclusion in the Procedure Guide as soon as possible. The protocols should address how much, if any information a social worker can reveal to a collateral contact to explain the need for assistance. They should also provide more general interview suggestions as to how to put a subject at ease and keep them talking, such as the use of open-ended questions, repeating the interviewee's words back to them as an inducement to further explanation, and the proper use of expectant silences to get people to elaborate.

Second, our review of the Department's Internet site shows that the For Your Information memoranda issued to social workers as clarifications or limited updates of items in the Procedure Guide were not complete, based on cross-references to memoranda that are still in force, but were not available on the web site. For example,

FYI 97-16, Questioning the Health Care Provider About Abuse, references FYI 96-29, Diagnostic Imaging: A Requirement for the Medical Examination for Physical Abuse and Severe Neglect Cases. However, the latter item was not available on the web site. Since the site contains selected memoranda dating from as long ago as 1995, we recommend that the Department review all bulletins issued from that year to the present, and make sure that those remaining in force are posted to the website for use by its staff and the public. We also recommend that the Department discontinue the use of these supplemental memoranda to amend existing procedures or create new ones. Arguably, the information in the two memos cited above might more appropriately be dealt with in a formal procedure describing the use of medical resources in abuse and neglect investigations. Instead, the FYI memos should be used to provide information about internal Department issues, such as changes in time reporting requirements or vacation request procedures. They could also be used to provide information related to but not part of Department procedures. For example, some procedures refer to requirements of case law. As new cases come to the Department's attention that social workers should be aware of, the FYI bulletins would be a good way to provide short descriptions of the requirements of such rulings for social workers to review and retain for reference purposes.

Finally, social workers in the focus group indicated that they occasionally refer to Department procedures, but not routinely. Several stated that the number of policies creates confusion, and the workload leaves little time to refer back to reference documents. One problem may be the lack of a manual geared specifically to the needs of Emergency Response and Dependency Investigation social workers. A specific manual has not been developed for these groups, as it has for the Hotline and for the Intake and Detention Control Unit. We recommend that such a document be developed. It could start with the Assessment Flow Chart, a document in the Procedure Guide that describes the investigation process, and should also include the Allegation Guide, the procedures on assessing various types of abuse and neglect, existing policies related to investigative contacts and the interview process, search warrant procedures, and the as yet undeveloped interview protocols previously discussed. The goal would be to provide a binder's worth of material that a social worker could carry with them in a vehicle, containing the key information a worker might need to refer to while investigating in the field.

CONCLUSION

To assist social workers in assessing allegations of child abuse and neglect, the Department of Children and Family Services (DCFS) requires use of "assessment tools" to determine which Child Abuse Hotline referrals should receive in-person investigation, and how soon, and to determine the risk to children who are the subject of in-person investigations, to decide whether to remove a child from the custodial parent. However, a review of 68 case files, and interviews with social workers, found

these tools are not always used, or are used in a perfunctory manner. For example in only 42.6 percent of the cases examined was the Assessment Guide used by Emergency Response social workers properly completed. Furthermore, this tool does not reflect the most current research in the field. Also, while the Department's procedures manual is extensive, there are gaps in some areas, and the manual is not formatted in a manner that would be easy for ER workers to refer to in the field. As a result, the Department is not assured that the goals of the assessment tools and procedures, which are to ensure consistency and accuracy in investigations, are met.

RECOMMENDATIONS

It is recommended that the Department of Children and Family Services:

3.1 Require Child Abuse Hotline social workers, as part of the screener narrative prepared for each report received, to indicate whether the Structured Decision-Making decision tree was completed, and if it was not, why it was not used. (Recommendation 140)

3.2 Implement the Structured Decision-Making system in place of the existing Assessment Guide completed by Emergency Response social workers, and present to social workers, as part of training in the new system, information showing its greater reliability. (Recommendation 141)

3.3 Complete the revision of the Department Procedure Guide by including the missing elements described in this section, particularly interviewing protocols. . (Recommendation 142)

3.4 Update the Department website regarding the For Your Information memoranda issued by management to staff, including copies of all currently active memos on the site. Revise the use of the FYI communication, limiting it to internal Department issues and updates to employees on relevant case law, for example. (Recommendation 143)

3. 5 Develop a procedure manual for Emergency Response and Dependency Investigation social workers, using parts of the Procedure Guide, similar to the manual already developed for Child Abuse Hotline staff. . (Recommendation 144)

SAVINGS AND BENEFITS

Use of the Structured Decision-making system by Emergency Response social workers should result in more reliable decision-making, based on existing research on the system, if training induces workers to use the system as intended. While the system provides more forms for social workers to fill out, it may be easier to use, because of the

point system used to determine whether the factors present for a particular child or family create a high, medium or low risk of abuse or neglect. Completing the revision of the Department's Procedure Guide, and creating a procedure manual for Emergency Response and Dependency Investigation social workers, can be completed with minimal additional cost in staff time and reproduction costs, and will provide a useful information source for these workers, providing only the key procedures related to their function.

Section 4. Use of CWS/CMS System by Social Workers

- **The Los Angeles County Department of Children and Family Services, similar to child welfare agencies in other California counties, uses the Child Welfare Services/Case Management System (CWS/CMS) to store and retrieve information on cases and to prepare case-related documents. However, our review of CWS/CMS information on 66 cases showed system use was irregular. In 15 of the 66 cases, 22.7 percent, one or more key documents prepared for the Superior Court were not stored on the system. Staff comments indicated that there is no Department policy requiring the use of CWS/CMS to prepare these documents, and that barriers to doing so include insufficient computer capacity at selected regional offices, and the inability to access CWS/CMS document formats away from regional offices.**

- **The irregular use of CWS/CMS requires key documents to be reviewed by searching for and reviewing a paper case file, rather than reviewing them more conveniently on line. This increases the chance that documents may be lost, and makes systematic evaluations of Department performance, such as that conducted for this study, more difficult.**

- **By improving computer capacity in regional offices, as called for in the Department's Phase II Strategic Plan, by pursuing portable methods for social workers to use CWS/CMS document formats, and by requiring social workers to prepare and store documents on CWS/CMS where available, the Department would ensure that key case information is available for case management and performance assessment purposes.**

Under State law approved in 1989, a statewide computer system was developed to automate functions of county child welfare departments. This system is known as the Child Welfare Services/Case Management System. According to a state Internet site:

> "The CWS/CMS system automates many of the tasks that county workers had to perform routinely and often manually. CWS/CMS allows for a centralized statewide system that allows State or county child welfare workers to share information on child abuse cases."

According to the State, counties began converting to CWS/CMS in January 1997, and on December 31, 1997, all counties had access to the system to carry out child welfare functions on line.

The system allows information to be accessed by a child's or parent's name, and also permits other identifying data, such as a Social Security Number, birth date,

approximate age and other information to be used to search for the information. The data contained in the electronic records for a particular child and/or family include notes of interviews conducted during investigations of child abuse and neglect, information on service providers to whom a family has been referred, electronic versions of key documents prepared by social workers, including Detention Reports, petitions and Jurisdictional Reports, and summaries of what occurred during court hearings involving the family.

As part of our review of case files for this audit, we reviewed information available for each case on the CWS/CMS system. At least partial information was available for 66 of the 68 cases reviewed. One case was not reviewed on the system, because of a name problem preventing the electronic record from being identified. A second case had only partial information, because this case represented a voluntary agreement by a parent to have a child removed from the home, and consequently court documents were not prepared.

Our review showed that use of CWS/CMS to prepare and store key documents was inconsistent. Among the items we searched for and reviewed on CWS/CMS were:

- The Detention Report prepared by Emergency Response social workers at the conclusion of an investigation when court intervention is being sought;

- The Addendum Report prepared by the Intake and Detention Control Unit (IDC) , which makes recommendations as to whether detention should continue and under what terms;

- The petition, the legal document prepared by (IDC), based on the Detention Report, alleging that a child has suffered or is at risk of suffering abuse and neglect as defined by Welfare and Institutions Code Section 300.

- The Jurisdictional/Disposition Report prepared by the Dependency Investigation social worker, presenting evidence in support of the allegations in the petition, and reporting on and making recommendations regarding what actions the Superior Court should take regarding the petition.

Our review identified 15 of the 66 cases, 22.7 percent, in which one ore more of these documents were missing from the electronic case file. Most often missing was the IDC Addendum report, which was missing from seven of the cases. The Detention Report and Jurisdictional/Disposition Report was missing from six cases each, while the petition was missing from three cases. Subsequent review of hard-copy case files found these documents for the cases, but the need to review hard-copy case files made this review more difficult, as it would any internal study carried out by the Department requiring review of case-file data. Furthermore, maintaining these key documents only

as hard copies, rather than electronically, increases the likelihood that they may be lost through handling.

Department training staff who assisted with providing us access to CWS/CMS indicated that one reason for the missing documents may be the lack of a specific Department policy requiring these documents to be prepared or stored on the system. Our review of the Department Procedure Guide confirmed that there is no specific requirement for preparing these documents via CWS/CMS, although the instructions for preparation of Detention Reports strongly imply that an on-line version of the document should be used. We recommend that the Department institute a specific policy requiring use of CWS/CMS for preparation of Detention Reports, Addendum Reports, petitions and Jurisdiction/Disposition Reports. If the access problem described below prevents the reports from being included with the electronic case file for a particular case at the time legal deadlines require the document to be prepared, the document should be attached electronically to the case file at a later date. This requirement should be enforced by Supervising Children's Social Workers who review and approve these documents after they are prepared by a social worker.

From our discussions with and observations of social workers and supervisors during this study, opinions regarding CWS/CMS appear significantly less hostile at DCFS than what we have observed in other counties. DCFS staff generally did not complain about the system's structure, or the difficulty of navigating it to find specific information. One worker, who complained about the time-consuming nature of entering contact information for cases into the system, also acknowledged that when receiving cases transferred from other staff, having easy access to that data makes it much easier to make decisions regarding a case, and quickly get familiar with it. This trade-off is the essence of why the system was developed. Staff also generally agreed that having electronic access to case file data is much easier than trying to read another social worker's handwritten case notes, which may not be legible.

Staff said problems with the system related to their ability to access it. Social workers from two different regional offices said they had been told that computer servers in the offices were too small, causing the system to crash frequently, and documents that had been prepared to be lost. The servers are computers that connect to the CWS/CMS system and store files from it. Those files can then be accessed by social workers from their individual computer workstations. One of the workers said at one point, staff did not have access to the system for a full two weeks. A third worker described a regional office where during some periods, workers who arrived at the office later than 8:30 a.m. were unable to access the system due to the limited capacity. Management staff at this same office also acknowledged this server capacity problem.

According to Phase II of the DCFS Strategic Plan, the Department's goals for Fiscal Year 2001-02 included, for the Bureau of Information Services to "strengthen network and

server availability and reliability." This goal was to be completed by June 2002, but apparently had not been completed by approximately April 1, when fieldwork for this audit was being conducted. This project should be completed as soon as possible, so that the CWS/CMS problems cited by social workers are alleviated.

The other access problem cited by workers is the inability to access CWS/CMS from anyplace other than their desks, which prevents them, for example, from updating information on one case in the field while waiting for a meeting on a second case.

Department management reports attempting to address this problem by purchasing word processing devices called Quickpads, and requesting the state to install versions of CWS/CMS document formats on them for use by social workers. According to the Department, State officials reported being unable to complete this project, and comments from social workers in this study indicated there is currently relatively limited use of these devices. Social workers did say they have found it helpful that many of the key documents they prepare use a standard Microsoft Word word processing program, which permits them to prepare the documents at home, then transfer them into CWS/CMS at their offices.

Furthermore, a pilot project carried out by the State in Riverside County in 2000, providing a version of the CWS/CMS contact reporting format on a notebook computer, received generally negative response from social workers, who said the laptops were too bulky, had insufficient battery life and presented a concern about theft. A separate pilot that was part of the same study found more positive reactions from social workers in Shasta County who used similar software on a personal digital device. During the entrance conference for this audit, the DCFS Director reported that the Department was pursuing purchase of such devices.

We recommend that the Department continue to seek methods by which social workers can enter data into CWS/CMS formats by means other than their desktop computers, such as the use of personal digital assistants and the software program developed for the State's pilot project, and the purchase of lighter, but very powerful notebook computers which are now available, and could permit the software developed by the State for its pilot project to more conveniently be used.

CONCLUSION

Use of CWS/CMS by social workers to prepare and store key court documents in child abuse and neglect cases is inconsistent, based on a review of 66 cases, which found that in 15 cases, one or more key documents were not stored on the system. DCFS staff cited inconsistent access to the system, due to insufficient computer capacity at regional offices, inability to access CWS/CMS document formats in the field and the lack of a

policy requiring use of CWS/CMS as factors contributing to the inconsistent system use.

RECOMMENDATIONS

It is recommended that the Department of Family and Children's Services

4.1 Develop a policy requiring social workers to use CWS/CMS for creation and storage of key court documents, including Detention Reports, Addendum Reports, petitions and Jurisdiction/Disposition Reports. This policy would be enforced by Supervising Children's Social Workers who review and approve these documents. (Recommendation 145)

4.2 Complete improvements to strengthen network and server availability and reliability, cited in the Department's Phase II Strategic Plan, as soon as possible. (Recommendation 146)

4.3 Pursue additional methods to provide data entry by social workers to CWS/CMS formatted documents while in the field, such as the personal digital assistant pilot project conducted by the State, or through the use of new lighter models of notebook computers that are now available. (Recommendation 147)

SAVINGS AND BENEFITS

By developing the policy requiring CWS/CMS use, the Department will ensure that key documents are stored electronically, making them easier for social workers to access and guarding against the loss of hard copies. Network and server improvements may require additional equipment and installation costs, which are not described in the Department's Phase II Strategic Plan. Furthermore, purchase of personal digital assistants or additional notebook computers also would increase equipment costs. However, making these improvements would increase social workers' use of CWS/CMS for document preparation and storage, thereby complying with the policy proposed here.

SOCIAL SERVICES COMMITTEE

Committee Investigation
Department of Children and Family Services

BACKGROUND

In addition to the audit findings and recommendations cited above, the Social Services Committee independently completed other investigations and made other findings and recommendations regarding the Department of Children and Family Services.

OBJECTIVE

The Social Services Committee recognized the need to promote an understanding about the court system and department procedures for the parent/caretaker.

METHODOLOGY

The Social Services Committee of the Los Angeles County Civil Grand Jury 2001-2002 met with administrative and line staff for the DCFS. The committee toured the DCFS Child Protective Hotline Center. The committee met with supervising personnel for Intake and Detention at the Edmund D. Edelman's Children's Court, and was given a tour of the court. The committee also met with members of Save Our Children, whose focus was to reunite the family.

FINDINGS

The Social Services Committee found that many of the parents/caretakers who had a child removed from their custody by DCFS, were not given an immediate or adequate explanation of the upcoming court procedures regarding the placement of their children. In many instances they were not informed of their rights or court procedures until they later appeared at a court hearing.

The committee found that the Judicial Council of California had published a brochure entitled Caregivers and the Courts - A Primer on Juvenile Dependency Proceedings for California Foster Parents and Relative Caregivers. This brochure contains information on the types of Dependency Court hearings, and caretaker's rights, which would be important for the child's parents understanding of the court system.

The committee found that many parents believed that DCFS did not provide them with an adequate means to write or voice their comments to DCFS and to the court as to how they thought the case plan for family reunification was progressing. Although the social worker's progress report contains a section for the parents' statements, many parents believed that the DCFS social worker was telling the court only what DCFS wanted known. In some cases, the parents believed that their statements regarding progress in gaining custody of their child were not fully communicated to the court or DCFS supervisors. It was found that no independent formal procedure was available for the parent to make written statements regarding family reunification plan progress through DCFS or the court.

RECOMMENDATIONS

148. The Social Services Committee recommends to the Department of Children and Family services that the Los Angeles County Ombudsman's Office should establish a volunteer training program and procedures for parent/caretaker advocates to assist the parent/caretaker when a child is removed from the home.

149. The Social Services Committee recommends to the Department of Children and Family Services that at the time a child is removed from home, the Department of Children and Family Services should provide the child's parent/caretaker with a brochure similar to the Judicial Council of California on Juvenile Dependency Proceedings. The brochure should contain a statement of parental rights, including the right to have an attorney, a written explanation of proceedings that will occur in upcoming court actions, and a referral to the County Ombudsman for assistance, if needed. The brochure should be written in the parent/caretaker's primary language.

150. The Social Services Committee recommends to the Department of Children and Family Services that it should establish a procedure, independent of the caseworker for the parent/ caretaker, to periodically evaluate the Family Reunification Plan progress. The evaluation should be read by the caseworker's supervisor and forwarded to the Dependency Court for the next court hearing.

SPEAKERS & EVENTS COMMITTEE

BACKGROUND

A Speakers and Events Committee of the Los Angeles County Civil Grand Jury 2001-2002 was established early in the term of the jury to coordinate educational experiences. These educational opportunities heightened the awareness of the Civil Grand Jury to the challenges facing all citizens of the community

OBJECTIVE

The responsibility of the Speakers and Events Committee was to arrange for speakers, tours and various field trips.

METHODOLOGY

Suggestions for speakers and tours for the Civil Grand Jury were submitted for consideration to the committee from the Civil Grand Jury members. Contact with the guest speakers was established and appointments were arranged once the committee approved the suggestions. Speakers were invited to the Civil Grand Jury Chambers. Transportation arrangements to outside events were made through the Los Angeles County Sheriff's Department.

The following distinguished guests presented various topics to the jury:

Michael Antonovich – Los Angeles County Supervisor
Lee Baca – Sheriff, Los Angeles County
Dr. Bryan Borys – Director, Organization Development & Education Los Angeles County
Bruce Brodie – Los Angeles County Alternate Public Defender's Offices, Head Deputy
Tony Butka – Los Angeles County Employee Relations Commission
Yvonne Brathwaite-Burke – Los Angeles County Supervisor
David P. Carleton – Los Angeles County Alternate Public Defender's Offices, Chief Deputy
Steve Cooley – District Attorney Los Angeles County
Sergio Diaz – Captain, Los Angeles Police Department
Judge Terry Friedman – Los Angeles Superior Court
David J. Gascon – Deputy Chief, Los Angeles Police Department (Chief of Staff)
Gloria Gomez – Los Angeles County Jury Services, Commissioner
David Janssen – Los Angeles County Chief Executive Officer
Don Knabe – Los Angeles County Supervisor
Susan Matherly – Administrator, Strategic Planning
Tyler McCauley – Los Angeles County Auditor Controller
Bernard C. Parks – Chief, Los Angeles Police Department
Robert Philibosian – Los Angeles County Citizens Economy & Efficiency Commission

Terrance Powell – Chief Environmental Health Specialist
Sylvia Saucedo – Los Angeles Police Commission
Hyatt Seligman – Los Angeles County Deputy District Attorney
Richard Shumsky – Los Angeles County Chief Probation Officer
Clinton Simmons – 2000-2001 Los Angeles County Civil Grand Jury Foreperson
Bruce Staniforth – Los Angeles County Citizens Economy & Efficiency Commission
David S. Wesley – Assistant Supervising Judge, Los Angeles Criminal Courts
Caprice Young – Board President, Los Angeles Unified School District

The Los Angeles County Civil Grand Jury made educational visits to:

Biscailuz Recovery Center
Boys Republic, Chino Hills
Criminal Courts Building Inmate Holding Facilities
Los Angeles City Harbor
Los Angeles County Coroner's Office
Los Angeles County Emergency Operations Center
Los Angeles County Men's Central Jail
Los Angeles County Sheriff's Department Communications Center
Los Angeles County Sheriff's Department Crime Laboratory
Los Angeles County Sheriff's Twin Tower Inmate Facilities
Los Angeles County Wayside Correctional Facilities
Los Angeles Police Department Crime Laboratory
Los Angeles Times Newspaper
MacLaren Children's Center

The Los Angeles County Civil Grand Jury attended the following special events:

Los Angeles County Board of Supervisors – Grand Jury Recognition Day
Los Angeles County Sheriff's Academy Graduation
Los Angeles Police Department Graduation
Los Angeles Sheriff's Department Memorial Service

IN APPRECIATION

This page is dedicated to the Los Angeles County Sheriff's Transportation Department. The Los Angeles County Civil Grand Jury 2001-2002 wishes to express its thanks for the help, concern, kindness, courtesy, and safe driving for the jury throughout its term of service.

Gilbert Zambrano

John Rivera

Arlen Rogers Susan Picklestreator

John Conteras Robert Owens

Edward Hopper Frank Mc Kay

10-29-01

Lawrence Felix

Sgt. Alton Green

Capt. Joe Gutierrez

RECOMMENDATIONS

The following are the recommendations made by Committees. Each recommendation is addressed to a specific board, department or entity within Los Angeles County. The California Penal Code specifies both the deadline by which responses shall be made to grand jury final reports, and the required content of those responses.

Edit Committee

GRAND JURY AND FINAL REPORT AWARENESS

1. The Edit Committee recommends that the Board of Supervisors continue and expand its "Grand Jury Awareness" campaign in an effort to help recruit volunteers for service on the Los Angeles County Civil Grand Jury.
   Respondent – Board of Supervisors

2. The Edit Committee recommends that the Board of Supervisors make available to the citizens of each of their districts, through their field offices, application forms for service on the Los Angeles County Civil Grand Jury.
   Respondent – Board of Supervisors

3. The Edit Committee recommends that the Board of Supervisors work with the Superior Court and its Jury Services staff to continue the distribution of the Los Angeles County Civil Grand Jury 2001-2002 final report, and each subsequent Civil Grand Jury final report, to the webmaster of the internet grand jury site, to post for public review via the internet.
   Respondent – Board of Supervisors and Los Angeles Superior Court

4. The Edit Committee recommends the Board of Supervisors work with the Superior Court and its Jury Services staff to provide copies of the Los Angeles County Civil Grand Jury 2001-2002 final report, and each subsequent Civil Grand Jury final report to all Los Angeles County Superior Court juror assembly rooms to help educate the public and recruit other interested volunteers.
   Respondent – Board of Supervisors and Los Angeles Superior Court

5. The Edit Committee recommends that the Board of Supervisors work with the Superior Court to continue and improve its educational outreach program, utilizing as many forms of media broadcasting as possible, in an attempt to recruit Civil Grand Jurors from the rich and diverse racial/ethnic population that encompasses the County of Los Angeles.
   Respondent – Board of Supervisors and Los Angeles Superior Court

Education Committee

LOS ANGELES UNIFIED SCHOOL DISTRICT

EXPENDITURE OF RESTRICTED STATE LOTTERY MONIES

6. The Education Committee recommends that the Los Angeles Unified School District establish separate funds for the receipt and expenditure of Lottery Monies in order to

ensure that such funds are expended in accordance with the restricted purposes specified by State law.
Respondent – Los Angeles Unified School District

7. The Education Committee recommends that the Los Angeles Unified School District develop written procedures to specify appropriate budgeting expenditure, and public hearing processes as described in Government Code Section 8880.4 and Education Code Section 60119.
Respondent – Los Angeles Unified School District

8. The Education Committee recommends that the Los Angeles Unified School District transfer approximately $14.3 million of General Fund monies to the Lottery Instructional Materials Special Fund to account for prior year expenditures not in compliance with Government Code Section 8880.4 restrictions.
Respondent – Los Angeles Unified School District

9. The Education Committee recommends that the Los Angeles Unified School District transfer approximately $13.0 million of General Fund monies to the Lottery Education Special Fund to account for prior year expenditures not in compliance with Government code Section 8880.4 restrictions.
Respondent – Los Angeles Unified School District

10. The Education Committee recommends that the Los Angeles Unified School District establish procedures to monitor the expenditure of lottery monies allocated to charter schools to ensure that such expenditures are in accordance with the restrictions of State law.
Respondent – Los Angeles Unified School District

11. The Education Committee recommends that the Board of Supervisors along with the Los Angeles Unified School District urge the State Legislature to amend Government Code Section 8880.4 to require local educational agencies to establish special funds for the receipt and expenditure of lottery educational and instructional material monies to ensure the use of such funds in accordance with the intent of State law. Further, a maintenance of effort requirement based on FY 1997-98 expenditure levels per ADA (average daily attendance) should be established and annually adjusted in accordance with annual changes in the consumer price index, to ensure local educational agencies do not supplant existing funding sources.
Respondent – Board of Supervisors and Los Angeles Unified School District

Government Operations Committee
ELECTRONIC VOTING MACHINES

12. The Government Operations Committee recommends that the Board of Supervisors should urge the Los Angeles County Registrar of Voters to evaluate more extensively the electronic voting machine, during voting, especially as to its acceptability by the voting public, the ease with which it is moved and handled, its vulnerability to functional

disruption accidentally or through intentional sabotage, and the accuracy with which it seems to operate.
Respondent – Board of Supervisors and Los Angeles County Registrar of Voters

13. The Government Operations Committee recommends that the Board of Supervisors should urge the United States Congressmen representing districts in the County of Los Angeles to urge the Federal Government to rescind the mandate preventing the use of punch-card voting techniques, until such time as a suitably constructed and adequately protected electronic voting machine has been satisfactorily tested.
Respondent – Board of Supervisors

14. The Government Operations Committee recommends that the Board of Supervisors should request from the Federal Government sufficient financing to cover the additional cost that the County of Los Angeles will incur if forced to adopt a new voting machine system before protection for the system has been provided, especially if the new machine involved must be adopted before the machine itself has been completely tested and proven.
Respondent – Board of Supervisors

15. The Government Operations Committee recommends that the Board of Supervisors should direct the County Registrar of Voters not to enlarge the area of voting districts without improving accommodations at and transportation to the new polling places.
Respondent – Board of Supervisors and Los Angeles County Registrar of Voters

Government Operations Committee
LOS ANGELES COUNTY COMMISSIONS

16. The Government Operations Committee recommends that the Los Angeles County Civil Grand Jury should maintain the established library of important Civil Grand Jury reference documents and reports.
Respondent – Civil Grand Jury

17. The Government Operations Committee recommends that subsequent Los Angeles County Civil Grand Juries should place in the permanent library file the list of Los Angeles County Commissions compiled by the Government Operations Committee of the 2001-2002 Civil Grand Jury.
Respondent – Civil Grand Jury

18. The Government Operations Committee recommends that subsequent Los Angeles County Civil Grand Juries should review this list of Los Angeles County Commissions annually and update it as necessary.
Respondent – Civil Grand Jury

Health & Human Services Committee
STROKE CENTERS

19. The Health & Human Services Committee recommends that the Department of Health Services should establish criteria for stroke centers that are compatible with American Medical Association guidelines.
    Respondent – Department of Health Services

20. The Health & Human Services Committee recommends that the Department of Health Services should add stroke centers to current trauma centers to address financing and to prevent duplication of personnel.
    Respondent – Department of Health Services

21. The Health & Human Services Committee recommends that the Department of Health Services should help settle catchment area controversies.
    Respondent – Department of Health Services

Health & Human Services Committee
ABANDONMENT OF NEWBORNS

22. The Health & Human Services Committee recommends that the Board of Supervisors should encourage the passage of the enabling legislation to release the allocated funds to publicize the provisions of SB 1368 (California Penal Code 271.5).
    Respondent – Board of Supervisors

23. The Health & Human Services Committee recommends that the Board of Supervisors should solicit as many public service announcements as possible from the local media, especially those venues that cater to younger people, to inform the public of this new law.
    Respondent – Board of Supervisors

24. The Health & Human Services Committee recommends that the Board of Supervisors should encourage hospitals, libraries, police and fire stations and sheriff facilities to display signs explaining the law.
    Respondent – Board of Supervisors

25. The Health & Human Services Committee recommends that the Board of Supervisors should encourage the boards of education in Los Angeles County to include information about the basics of SB 1368 in health curricula.
    Respondent – Board of Supervisors

26. The Health & Human Services Committee recommends that the Board of Supervisors should designate a specific day or week to publicize the abandoned baby problem.
    Respondent – Board of Supervisors

27. The Health & Human Services Committee recommends that the Board of Supervisors should designate other appropriate facilities to accept unwanted newborn.
    Respondent – Board of Supervisors

Health & Human Services Committee
PATIENT ADVOCATES

28. The Health & Human Services Committee recommends that the Board of Supervisors should initiate a study of hospitals with a county contract that have advocacy programs and those that do not. They should compare patient and financial outcomes to determine the value of an advocacy program to the patient and to the hospital.
    Respondent – Board of Supervisors

29. The Health & Human Services Committee recommends that the Department of Health Services should direct their hospitals to start a program of patient advocacy training for volunteers. Conflicts of interest with the hospital would be less likely to arise than if a patient advocate were an employee of the hospital.
    Respondent – Department of Health Services

30. The Health & Human Services Committee recommends that the Department of Health Services should direct their hospitals to disseminate information on the patient advocacy programs in their hospitals upon patient admission, with emphasis on just what services are available to patients and their families. This information should stress the independent nature of the program as a means of good public and patient relations.
    Respondent – Department of Health Services

Health & Human Services Committee
RETAIL FOOD INSPECTION

31. The Health & Human Services Committee recommends that the Instructors in the Environmental Health Division of the Department of Health Services should include inspector training regarding body mechanics to prevent their having back and joint problems.
    Respondent – Department of Health Services

32. The Health & Human Services Committee recommends that the Environmental Health Division of the Department of Health Services should design and provide a tool belt to hold the equipment that all inspectors must carry.
    Respondent – Department of Health Services

33. The Health & Human Services Committee recommends that the Environmental Health Division of the Department of Health Services should consider a professional work garment that would preserve the inspectors' clothes and that could either be used in conjunction with a tool belt or have pockets and loops that would obviate the need for a tool belt. The negative impact of this recommendation is that if the garment were distinctive enough, the restaurant personnel would recognize the inspector and that would give them some warning if surprise were to be a factor.
    Respondent – Department of Health Services

34. The Health & Human Services Committee recommends that if the personnel in the restaurant are not fluent in English, or if language subtleties could present problems, the Department of Health Services should try to match the inspectors who could speak the language with the language spoken at the restaurant.
Respondent – Department of Health Services

Jails Committee

JUVENILE DETENTION FACILITIES

35. The Jails Committee recommends that the Probation Department should hire an adequate number of personnel to provide for the safety of the staff and detainees at all camps. If the Probation Department cannot fund staff needs, the Board of Supervisors should address funding shortfalls.
Respondent – Probation Department and Board of Supervisors

36. The Jails Committee recommends that the Probation Department should require new staff to spend a minimum of two years at the same training facility before rotation to a new facility.
Respondent – Probation Department

37. The Jails Committee recommends that the Probation Department should arrange for the immediate repair of all gymnasiums and swimming pools in the camp system.
Respondent – Probation Department

38. The Jails Committee recommends that the Probation Department should implement additional and more varied occupational training programs for juvenile detainees.
Respondent – Probation Department

39. The Jails Committee recommends that the Probation Department should allow camp directors more discretion to contract with outside vendors for emergency maintenance problems and in some cases, regular maintenance.
Respondent – Probation Department

40. The Jails Committee recommends that the Probation Department directors and Los Angeles County Office of Education principals at each facility should be required to submit priority maintenance lists monthly to Internal Services Division.
Respondent – Probation Department and Los Angeles County Office of Education (LACOE)

41. The Jails Committee recommends that the Board of Supervisors should require the Internal Services Division to reprioritize maintenance schedules and place more emphasis on the camp's needs.
Respondent – Probation Department and Internal Services Division

42. The Jails Committee recommends that the Probation Department should expand its effort to seek public grants and private partnerships to fill needs throughout the camp system. Sponsorships and corporate "adoption" programs should be considered.
Respondent – Probation Department

43. The Jails Committee recommends that the Probation Department should establish a relationship with California National Guard and other military units to procure clothing for the camp detainees.
Respondent – Probation Department

44. The Jails Committee recommends that the Probation Department should purchase stand-alone generators to provide power during outages for all juvenile facilities.
Respondent – Probation Department

45. The Jails Committee recommends that the Probation Department should replace outdated hand held-radios and ensure there are sufficient quantities to provide for the safety of staff and detainees. The Probation Department should make inquiries to other County departments that may be replacing aging but workable hand-held radios.
Respondent – Probation Department

46. The Jails Committee recommends that the Probation Department should never allow the installation of adult probation electronic monitoring equipment at any juvenile facility.
Respondent – Probation Department

47. The Jails Committee recommends that the Probation Department should move candy and soft drink vending machines visible on the camp grounds out of the view of the detainees.
Respondent – Probation Department

Jails Committee

ADULT DETENTION FACILITIES

48. The Jails Committee recommends that the Sheriff's Department and Los Angeles Police Department should confer and establish a procedure to update all required documents including, Titles 15 and 24, department policy manuals, facility evacuation plans and procedures in their detention facilities. This information should be easily accessible to the jailers.
Respondent – LASD and LAPD

49. The Jails Committee recommends that the Sheriff's Department should establish a procedure that requires copies of yearly fire inspections to be kept with the jailer.
Respondent – LASD

50. The Jails Committee recommends that the Los Angeles Police Department should establish a procedure that requires copies of yearly fire inspections to be kept with the jailer.
Respondent – LAPD

51. The Jails Committee recommends that the Los Angeles Police Department should supply fire fighting turnout gear in any facility that requires fire fighting air packs.
Respondent – LAPD

52. The Jails Committee recommends that the Sheriff's Department should supply fire fighting turnout gear in any facility that requires fire fighting air packs.
Respondent – LASD

53. The Jails Committee recommends that the Los Angeles Police Department should provide first aid kits in each detention facility (only 15% of the facilities inspected had any form of first aid kit). They should meet minimum standards set by the American Red Cross.
Respondent – LAPD

54. The Jails Committee recommends that the Sheriff's Department should provide first aid kits in each detention facility (only 15% of the facilities inspected had any form of first aid kit). They should meet minimum standards set by the American Red Cross.
Respondent – LASD

55. The Jails Committee recommends that the Los Angeles Police Department should provide automatic defibrillators in all detention facilities. The paramedic response time to most facilities was greater than five minutes, considered to be the upper limit of survival time for cardiac arrest victims.
Respondent - LAPD

56. The Jails Committee recommends that the Sheriff's Department should provide automatic defibrillators in all detention facilities. The paramedic response time to most facilities was greater than five minutes, considered to be the upper limit of survival time for cardiac arrest victims.
Respondent LASD

57. The Jails Committee recommends that the Sheriff's Department should enforce policies regarding sanitary conditions in their facilities as mandated in Title 15, Article 14, §1280.
Respondent - LASD

58. The Jails Committee recommends that the Los Angeles Police Department should enforce policies regarding sanitary conditions in their facilities as mandated in Title 15, Article 14, §1280.
Respondent - LAPD

59. The Jails Committee recommends that the Sheriff's Department should provide fax and copy machines in each facility that relies on prompt communications between the facility and the courts concerning the disposition of detainees.
Respondent - LASD

60. The Jails Committee recommends that the Los Angeles Police Department should provide fax and copy machines in each facility that relies on prompt communications between the facility and the courts concerning the disposition of detainees.
Respondent - LAPD

61. The Jails Committee recommends that the Sheriff's Department should maintain an adequate inventory of restraining devices (leg chains) at each facility where transportation of detainees occurs.
Respondent LASD

62. The Jails Committee recommends that the Board of Supervisors should establish a timeline to replace aging custodial facilities. The Sheriff's Department will have to refurbish or rebuild at least six facilities each year for the next ten years to meet predicted inmate population increases. Consideration should be given to the Inmate Welfare Fund as a funding source.
Respondent – Board of Supervisors

63. The Jails Committee recommends that the Sheriff's Department, in conjunction with the managers at the North County Correctional Facility, should immediately contract to replace the shower floors, re-pipe the prisoner portion of the facility, and replace the hot water boilers. Using the Inmate Welfare Fund as a funding source should be considered.
Respondent – LASD

64. The Jails Committee recommends that the Sheriff's Department should install a security camera system at the North County Correctional Facility to assist in monitoring the inmate population.
Respondent - LASD

65. The Jails Committee recommends that the Sheriff's Department should install a computerized law library program, such as Lexis Reference Library at the North County Correctional Facility for inmates acting in pro per.
Respondent - LASD

66. The Jails Committee recommends that the Board of Supervisor should initiate an assessment of the practices and effectiveness of rehabilitation programs currently in use in the prison system.
Respondent – Board of Supervisors

67. The Jails Committee recommends further that based on the outcome of the study, emphasis could be refocused on the programs that offer the greatest potential to enable inmates to achieve success when they return to the community.
Respondent – Board of Supervisors

Jails Committee
INMATE WELFARE FUND

68. The Jails Committee of the Los Angeles County Civil Grand Jury 2001-2002 recommends to the succeeding grand juries that they monitor the IWF for compliance with the law and its own policies.
Respondent – Civil Grand Jury

69. The Jails Committee of the Los Angeles County Civil Grand Jury 2001-2002 recommends that succeeding grand juries scrutinize the IWF expenditures (or lack thereof) to see that the accumulation of monies is not excessive and monies are being prudently applied to meet the Sheriff's mandate of providing services to the inmates.
Respondent – Civil Grand Jury

70. The Jails Committee recommends that the Sheriff's Department refine the procedures manual by including in its policies a specific percentage of the IWF balance to be set aside in each budget year for new pilot programs.
Respondent – LASD

71. The Jails Committee recommends that the Sheriff's Department state in the Welfare Commission Fiscal Handbook that not only will 51% of the IWF balance be budgeted, but also spent on inmate programs each year. If any portion of the inmate program money is not spent, it should be carried over to the next fiscal year as funds for inmate programs only. It should not be co-mingled with facility maintenance funds.
Respondent - LASD

Jails Committee
BISCAILUZ RECOVERY CENTER
BRIDGES TO RECOVERY DOMESTIC VIOLENCE PROGRAM

72. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to develop guidelines and procedures for determining (a) how the Bridges to Recovery Center Program goals will be achieved, and (b) how inmates and program staff will identify when those goals have been achieved.
Respondent - LASD

73. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to develop measurable and reasonable objective criteria for determining program success, and a process to ensure that such criteria are communicated to inmates and staff. **Respondent - LASD**

74. The Jails Committee recommends that the Sheriff should direct the Correctional services Division managers to develop and implement policies and procedures necessary for maintaining inmates for as close to the 6-week program curriculum as possible.
Respondent - LASD

75. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to document a formalized process for screening inmates for program admission that includes all criteria to be used by screening personnel.
Respondent - LASD

76. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to train additional personnel on eligibility and admission screening procedures.
Respondent - LASD

77. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to establish a formalized process for documenting eligibility screening results, so that the pool of potential program candidates, and selected and rejected candidates can be identified by reason.
Respondent - LASD

78. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to limit Bridges to Recovery program participation to inmates with a clear domestic violence criminal history.
Respondent - LASD

79. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to establish procedures to ensure that adopted screening criteria are consistently applied.
Respondent - LASD

80. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to work with Hacienda La Puente School District managers to incorporate program assessment criteria into the LASD screening process.
Respondent – LASD

81. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to establish a formalized inmate orientation process, which includes standard materials and relies upon staff who have been fully trained in aspects of the program.
Respondent - LASD

82. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers, with the Hacienda La Puente School District, develop a more extensive and formal process for transitioning inmates into the community, which includes involvement of the LASD Community Transition Unit and the Los Angeles County Probation Department.
Respondent – LASD

83. The Jails Committee recommends that the Hacienda La Puente School District Superintendent should direct Correctional Education division managers to consider increasing counselor hours to assist inmates with community transition. **Respondent – Hacienda La Puente School District Superintendent**

84. The Jails Committee recommends that the Hacienda La Puente School District Superintendent should direct Correctional Education Division managers to establish mechanisms to ensure that the Bridges to Recovery Program classes mirror formalized course descriptions, course goals and objectives.
Respondent – Hacienda La Puente School District Superintendent

85. The Jails Committee recommends that the Hacienda La Puente School District Superintendent should direct Correctional Education Division managers to establish systems to ensure that course instructors are able to determine whether students have successfully met class objectives.
Respondent – Hacienda La Puente School District Superintendent

86. The Jails Committee recommends that the Hacienda La Puente School District superintendent should direct Correctional Education Division managers to develop measurable and reasonable course objectives and methods for measuring objectives, including pre and post testing for all course groupings.
Respondent – Hacienda La Puente School District Superintendent

Jails Committee
BISCAILUZ RECOVERY CENTER
PROFILE OF PROGRAM PARTICIPANTS

87. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to expand future statistical analyses and surveys to include all participants in the program, and to include more data elements (as described in the body of this report).
Respondent LASD

88. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers, with the help of Hacienda La Puente School District, to develop a single database of information for tracking inmate participation in the Bridges to Recovery Program.
Respondent - LASD

89. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to ensure that criminal change data is accurately recorded so that it can be ascertained that the program focus remains on domestic violence.
Respondent - LASD

90. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to review the inmate selection process, and establish procedures that

will ensure that only those inmates with six weeks left on their sentences (approximate) are enrolled in the program.
Respondent - LASD

91. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to ensure that reasons for dropping an inmate from the program are consistently and reliably tracked.
Respondent - LASD

92. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to develop a formalized process for dealing with inmates who are not progressing through the program in an expected timeframe.
Respondent - LASD

93. The Jails Committee recommends that the Superintendent of the Hacienda La Puente School District should direct Correctional Education Division managers to work with the Sheriff's Department to establish a single database of information for tracking inmate participation in the Bridges to Recovery Program.
Respondent - LASD

94. The Jails Committee recommends that the Superintendent of the Hacienda La Puente School District should direct Correctional Education Division managers to work with the Sheriff's Department to establish protocols for dealing with inmates who are not meeting program criteria and objectives in a timely manner.
Respondent - LASD

Jails Committee
BISCAILUZ RECOVERY CENTER
<u>PROGRAM COSTS</u>

95. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to develop and implement an appropriate model for measuring the average cost per inmate day, the average cost per program participant and the average cost per program graduate for the Bridges to Recovery Program.
Respondent - LASD

96. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to incorporate the results of the cost model into a comprehensive cost-effectiveness evaluation, as discussed in Section 4.
Respondent – LASD

Jails Committee
BISCAILUZ RECOVERY CENTER
PROGRAM RESULTS

97. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to develop and formalize quantifiable measures of program success, which are directly linked to program goals and objectives.
Respondent - LASD

98. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to establish consistent methods for capturing performance data.
Respondent - LASD

99. The Jails Committee recommends that the Sheriff should direct the Correctional Services Division managers to work with the Hacienda La Puente School District to develop additional data elements which will assist with future evaluation of the Bridges to Recovery Program, including the reasons individuals do not graduate, release dates, release reasons, etc.
Respondent - LASD

Public Safety Committee
VEHICLE PULLOVERS – RACIAL BIAS/PROFILE TRAINING
SEARCH AND SEIZURE TRAINING
MEDIATION AND DISPUTE RESOLUTION SKILLS TRAINING

100. The Public Safety Committee recommends that the Los Angeles Police Department and Los Angeles Sheriff's Department should continue their education and training programs in areas of officer's interaction with the public and treatment of crime suspects and prisoners.
Respondent – LAPD and LASD

101. The Public Safety Committee recommends that the Los Angeles Police Department and Los Angeles Sheriff's Department should continue to provide follow up training as the evolution of case law may dictate, particularly in the area of search and seizure.
Respondent – LAPD and LASD

102. The Public Safety Committee recommends that the Los Angeles Police Department and Los Angeles Sheriff's Department should continue to emphasize and provide continuing education in the specialized areas of dispute resolution, conflict management and mediation in an effort to seek constantly alternate ways of establishing positive communication while upholding the Vision, Mission and Core Values of the Departments.
Respondent – LAPD and LASD

103. The Public Safety Committee recommends that the Los Angeles Police Department should continue its attention to implement the terms and conditions of the

Department of Justice Consent Decree document, which was mutually agreed upon, formally approved and signed on June 15, 2001.
Respondent - LAPD

Social Services Committee
MACLAREN CHILDREN'S CENTER
POPULATION PROFILE

104. The Social Services Committee recommends that the Interagency Children's Services Consortium request that the Director of Mental Health services at MacLaren prepare a proposal for a program to replace Children's Social Workers and Group Supervisors with mental health staff in the cottages to provide a more therapeutic approach appropriate to much of the population at MacLaren.
Respondent – Interagency Children's Services Consortium

105. The Social Services Committee recommends that the Interagency Children's Services Consortium request that the Director of Mental Health services at MacLaren prepare measures of effectiveness or outcomes for review and approval by the Consortium to use in measuring the results of the proposed program.
Respondent – Interagency Children's Services Consortium

106. The Social Services Committee recommends that the Interagency Children's Services Consortium, after review and approval of the proposal, implement on a pilot basis and measure results to ensure that desired results are achieved or, if not, determine what changes are needed.
Respondent – Interagency Children's Services Consortium

107. The Social Services Committee recommends that the Interagency Children's Services Consortium replicate the program throughout the facility once its effectiveness has been established.
Respondent – Interagency Children's Services Consortium

108. The Social Services Committee recommends that the Interagency Children's Services Consortium collect evidence to verify the effectiveness of programs such as Wraparound and expand to the extent possible.
Respondent – Interagency children's Services Consortium

Social Services Committee
MACLAREN CHILDREN'S CENTER
CRIMINAL BACKGROUND CHECKS

109. The Social Services Committee recommends that MacLaren Children's Center immediately bring all staff and contractors assigned to the facility who have or could have contact with children there in compliance with CDSS and MacLaren policies regarding background checks.

Respondent – MacLaren Children's Center

110. The Social Services Committee recommends that MacLaren Children's Center seek an agreement with Los Angeles County Office of Education (LACOE) regarding the background checks of employees assigned to the MacLaren School, in which LACOE agrees to provide MacLaren with legally certified documentation regarding the results of background checks conducted of LACOE staff. Additionally, LACOE should agree to abide by MacLaren policies regarding background checks for those LACOE staff assigned to the facility. Should such an agreement not prove feasible, then MacLaren should review its options relative to alternative providers of educational services at the facility.
Respondent – MacLaren Children's Center

111. The Social Services Committee recommends that MacLaren Children's Center clarify the California laws and regulations regarding the storage of criminal background checks. Work to ensure that criminal background checks record-keeping is consistent for all employees assigned at MacLaren and that records are auditable.
Respondent – MacLaren Children's Center

112. The Social Services Committee recommends that MacLaren Children's Center document its policies and procedures relative to background checks and ensure that all County agencies and other parties operating at the facility are aware of these policies and procedures and are in compliance with them.
Respondent – MacLaren Children's Center

113. The Social Services Committee recommends that MacLaren Children's Center document background checks conducted for all contractors and their employees operating at the facility, including those contracted with the DCFS, DMH, DHS and LACOE
Respondent – MacLaren Children's Center

114. The Social Services Committee recommends that LACOE immediately conduct background checks on those employees assigned to MacLaren who have not undergone a background check, and document the results of all background checks conducted, with a legal certification as to the truth and accuracy of the information.
Respondent - LACOE

Social Services Committee
MACLAREN CHILDREN'S CENTER
<u>INVESTIGATING ALLEGATIONS OF ABUSE BY STAFF</u>

115. The Social Services Committee recommends that the MacLaren Children's Center Administrator relieve the Children's Services Administrators (CSA's) currently conducting the preliminary investigations of this duty, as their positions and reporting relationships do not provide the independence necessary to perform this function effectively. **Respondent – MacLaren Children's Center Administrator**

116. The Social Services Committee recommends that the MacLaren Children's Center Administrator assign a manager, preferably one with investigations/auditing skills, to focus primarily on investigations of allegations of abuse by staff against children at the facility. This individual should have complete independence and autonomy from all other manages and staff at the facility and should report directly to the Administrator. **Respondent – MacLaren Children's Center Administrator**

117. The Social Services Committee recommends that the MacLaren Children's Center Administrator direct the new investigator to conduct timely investigations and prepare timely, complete and accurate reports and to produce a quarterly report to be presented to the Administrator regarding the status and outcomes of activities in this area for that quarter. **Respondent – MacLaren Children's Center Administrator**

118. The Social Services Committee recommends that the MacLaren Children's Center Administrator use the quarterly as well as individual investigations reports to ensure that the investigations are being managed in a timely and effective fashion, and problems corrected. **Respondent – MacLaren Children's Center Administrator**

119. The Social Services Committee recommends that the MacLaren Children's Center Administrator update MacLaren's policies and procedures relative to Special Incident reporting, including the timeframes and documentation component, and key personnel involved in the process. The policies also should address the code of silence among staff, and put forth concrete consequences for anyone found to have obstructed an investigation of allegations of abuse by staff against children at the facility. This update should include a training element, during which staff are instructed on the policies and procedures and about the importance of timely and proper documentation.
Respondent – MacLaren Children's Center Administrator

120. The Social Services Committee recommends that the Interagency Children's Services Consortium direct DCFS to continue to address the investigation backlog and give it the highest priority. DCFS should be instructed to report back to the Consortium within six months as to the status of the backlog.
Respondent – Interagency Children's Services Consortium

Social Services Committee
MACLAREN CHILDREN'S CENTER
<u>RECRUITMENT, HIRING AND ITEM CONTROL</u>

121. The Social Services Committee recommends that the Interagency Children's Services Consortium increase accountability and overall efficiency and effectiveness at MacLaren by revising the Operational Agreement to include more specific and detailed agreements with all parties assigned to the facility, giving the MacLaren Administrator final decision making authority as to staffing types and levels at the facility, including disciplinary actions up to and including dismissal from the facility.
Respondent – Interagency Children's Services Consortium

122. The Social Services Committee recommends that the Interagency Children's Services Consortium, in areas in which specific expertise is required to make efficient and effective staffing decision, ensure that MacLaren have its own experts, either on staff or as consultants, who can advise management as to the best configuration.
Respondent – Interagency Children's Services Consortium

123. The Social Services Committee recommends that the Interagency Children's Services Consortium review options for using non-County service providers who are more able or willing to work within the proposed management framework and transfer current County costs to that provider from the department or agency in question should one of the entities be unable or not wish to participate in the recommended amendments to the Operational Agreement.
Respondent – Interagency Children's Services Consortium

124. The Social Services Committee recommends that the Interagency Children's Services Consortium require staff from all agencies to report monthly to the Human Resources Director at MacLaren regarding the total staffing from their department, including new hires, resignations, terminations and transfers. Those agencies not complying with this requirement should be reviewed for suitability to continue their assignment at the facility.
Respondent – Interagency Children's Services Consortium

Social Services Committee
MACCLAREN CHILDREN'S CENTER
COST/STAFFING ANALYSIS

125. The Social Services Committee recommends that the Interagency Children's Services Consortium direct staff to develop a cost tracking and reporting system so that all budget and actual expenditures are consolidated, reviewed and approved by the MacLaren Administrator and reported to the Consortium.
Respondent – Interagency Children's Services Consortium

126. The Social Services Committee recommends that the Interagency Children's Services Consortium direct staff to delegate authority over funding and service levels for all services at MacLaren to the Administrator.
Respondent – Interagency Children's Services Consortium

127. The Social Services Committee recommends that the Interagency Children's Services Consortium revise procurement policies so that the Administrator is responsible and accountable for all procurement at MacLaren Children's Center.
Respondent – Interagency Children's Services Consortium

128. The Social Services Committee recommends that the Interagency Children's Services Consortium direct staff to design and implement performance measurement systems for measuring outcomes of existing and any new proposed staffing or services.
Respondent – Interagency Children's Services Consortium

129. The Social Services Committee recommends that the Interagency Children's Services Consortium consider alternative staffing levels and approaches to obtain desired outcomes including eliminating barriers between agencies so that managers can assume responsibility for staff from different agencies and the number of managers can be reduced.
Respondent – Interagency Children's Services Consortium

130. The Social Services Committee recommends that the Interagency Children's Services Consortium consider and obtain comparative cost information for contracting for services now provided by various County agencies if they are unwilling to relinquish control over service and staffing levels to the MacLaren Administrator.
Respondent – Interagency Children's Services Consortium

131. The Social Services Committee recommends that the Interagency Children's Services Consortium establish a policy of reducing costs in the parent agencies when administrative functions are transferred to MacLaren.
Respondent – Interagency Children's Services Consortium

132. The Social Services Committee recommends that the Interagency Children's Services Consortium obtain comparative cost information regarding contracting for all services at MacLaren.
Respondent – Interagency Children's Services Consortium

Social Services Committee
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
<u>ABUSE AND NEGLECT INVESTIGATIONS</u>

133. The Social Services Committee recommends that the Department of Children and Family Services research why the percentage of petitions not filled for insufficient evidence by the Intake and Detention Control Unit has fallen in recent years, and develop a system to gather data on IDC rejections by regional offices and by individual social workers, in order to identify systematic performance differences that require correction.
Respondent – Department of Children and Family Services

134. The Social Services Committee recommends that the Department of Children and Family Services request that the Superior Court, if possible, provide information on a regional office and individual social worker basis on petitions dismissed at Detention Hearings or Jurisdictional Hearings, in order to identify performance differences that require correction.
Respondent – Department of Children and Family Services

135. The Social Services Committee recommends that the Department of Children and Family Services conduct periodic case file reviews, similar to that reported in this section, to assess the quality of investigations conducted by Emergency Response and Dependency Investigation social workers. These reviews should include samples of cases in each region. Such reviews should be conducted by the Department's Quality Assurance Unit. According to the Department, a monthly system of such reviews will begin in June 2002

Respondent – Department of Children and Family Services

Social Services Committee

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

DOCUMENTATION OF REASONABLE EFFORTS

136. The Social Services Committee recommends that the Department of Children and Family Services consult with County Counsel on the content that should be included in describing reasonable efforts made to eliminate the need to take children into protective custody.

Respondent – Department of Children and Family Services

137. The Social Services Committee recommends that the Department of Children and Family Services issue a memo to all Emergency Response social workers emphasizing the need to include in Detention Reports detailed descriptions of the reasonable efforts provided to families investigated for abuse and neglect allegations, or more detailed information on the emergent circumstances of the case that made it feasible to provide such reasonable efforts.

Respondent – Department of Children and Family Services

138. The Social Services Committee recommends that the Department of Children and Family Services require the intake and Detention Control Unit to track whether reports contain a properly detailed description of reasonable efforts, preparing a monthly report indicating the percentage, by regional office, which do not meet the new standards. This monthly reporting should be provided for one year after Recommendation 135 is implemented, and may be reduced to spot-checking Detention Reports thereafter, assuming the incidence of violations is sufficiently low.

Respondent – Department of Children and Family Services

139. The Social Services Committee recommends that the Department of Children and Family Services develop a services handbook for Emergency Response Command Post workers to carry, utilizing information on available service resources that has already been developed by regional offices.

Respondent – Department of Children and Family Services

Social Services Committee
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
USE OF ASSESSMENT TOOLS AND PROCEDURES

140. The Social Services Committee recommends that the Department of Children and Family Services require Child Abuse Hotline social workers, as part of the screener narrative prepared for each report received, to indicate whether the Structured Decision-Making decision tree was completed, and if it was not, why it was not used.
Respondent – Department of Children and Family Services

141. The Social Services Committee recommends that the Department of Children and Family Services implement the Structured Decision-Making system in place of the existing Assessment Guide completed by Emergency Response social workers, and present to social workers, as part of training in the new system, information showing its greater reliability.
Respondent – Department of Children and Family Services

142. The Social Services Committee recommends that the Department of Children and Family Services complete the revision of the Department Procedure Guide by including the missing elements described in this section, particularly interviewing protocols.
Respondent – Department of Children and Family Services

143. The Social Services Committee recommends that the Department of Children and Family Services update the Department website regarding the For Your Information memoranda issued by management to staff, including copies of all currently active memos on the site. Revise the use of the FYI communication, limiting it to internal Department issues and updates to employees on relevant case law, for example.
Respondent – Department of Children and Family Services

144. The Social Services Committee recommends that the Department of Children and Family Services develop a procedure manual for Emergency Response and Dependency Investigation social workers, using parts of the Procedure Guide, similar to the manual already developed for Child Abuse Hotline staff.
Respondent – Department of Children and Family Services

Social Services Committee
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
USE OF CWS/CMS SYSTEM BY SOCIAL WORKERS

145. The Social Services Committee recommends that the Department of Children and Family Services develop a policy requiring social workers to use CCWS/CMS for creation and storage of key court documents, including Detention Reports, Addendum Reports, petitions and Jurisdiction/Disposition Reports. This policy would be enforced by Supervising Children's Social Workers who review and approve these documents.
Respondent – Department of Children and Family Services

146. The Social Services Committee recommends that the Department of Children and Family Services complete improvements to strengthen network and server availability and reliability, cited in the Department's Phase II Strategic Plan, as soon as possible.
Respondent – Department of Children and Family Services

147. The Social Services Committee recommends that the Department of Children and Family Services pursue additional methods to provide data entry by social workers to CWS/CMS formatted documents while in the field, such as the personal digital assistant pilot project conducted by the State, or through the use of new lighter models of notebook computers that are now available.
Respondent – Department of Children and Family Services

Social Services Committee
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
COMMITTEE INVESTIGATION

148. The Social Services Committee recommends to the Department of Children and Family services that the Los Angeles County Ombudsman's Office should establish a volunteer training program and procedures for parent/caretaker advocates to assist the parent/caretaker when a child is removed from the home.
Respondent – Department of Children and Family Services

149. The Social Services Committee recommends to the Department of Children and Family Services that at the time a child is removed from home, the Department of Children and Family Services should provide the child's parent/caretaker with a brochure similar to the Judicial Council of California on Juvenile Dependency Proceedings. The brochure should contain a statement of parental rights, including the right to have an attorney, a written explanation of proceedings that will occur in upcoming court actions, and a referral to the County Ombudsman for assistance, if needed. The brochure should be written in the parent/caretaker's primary language.
Respondent – Department of Children and Family Services

150. The Social Services Committee recommends to the Department of Children and Family Services that it should establish a procedure, independent of the caseworker for the parent/ caretaker, to periodically evaluate the Family Reunification Plan progress. The evaluation should be read by the caseworker's supervisor and forwarded to the Dependency Court for the next court hearing.
Respondent – Department of Children and Family Services

RESPONSES

RESPONSES

The California Penal Code specifies both the deadline by which responses shall be made to grand jury final report recommendations, and the required content of those responses.

DEADLINE FOR REPSONSES

Penal Code Section 933 (c) states:

> *"Not later than 90 days after the grand jury submits a final report on operations of any public agency subject to its reviewing authority, the governing body of the public agency shall comment to the presiding judge of the superior court on the findings and recommendations pertaining to matters under the control of the governing body, and every elective county officer or agency head for which the grand jury has responsibility pursuant to Section 914.1 shall comment within 60 days to the presiding judge of the superior court, with an information copy sent to the board of supervisors, on the findings and recommendations pertaining to matters under the control of that county officer or agency head and any agency or agencies which that officer or agency head supervises or controls. In any city and county, the mayor shall also comment on the findings and recommendations . . ."*

The code requires that responses from governing bodies and elected officer and agency heads be made to the presiding judge. The 90-day deadline applies to the governing body required to respond to a grand jury report. The 60-day deadline applies to an elected county officer or agency head.

CONTENT OF RESPONSES

Recommendations –

For each grand jury *recommendation*, the responding person or entity shall report one of the following actions:

- The recommendation has been implemented, with a summary regarding the implemented action.
- The recommendation has not been implemented, but will be implemented in the future, with a time frame for implementation.
- The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame from the matter to be prepared for discussion by the officer or head of the agency

or department being investigated or reviewed, including the governing body of the public agency when applicable. This time frame shall not exceed six months from the date of publication of the grand jury report.

- The recommendation will not be implemented because it is unwarranted or unreasonable, with a supportive explanation.

RESPOND TO

Responses to grand jury final report recommendations should be sent to:

The Honorable James A. Bascue
Presiding Judge
Los Angeles County Superior Court
111 North Hill Street
Room 222
Los Angeles, California 90012