Audit of the Child Protective Services System

A Report to the Governor and the Legislature of the State of Hawaii

Report No. 99-5
January 1999

THE AUDITOR
STATE OF HAWAII

OVERVIEW

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Summary

Agencies charged with protecting children from abuse and neglect include the Department of Human Services (DHS), the Department of the Attorney General, the Family Court, and the four counties' police departments. The 1998 Legislature, in Senate Concurrent Resolution No. 146, S.D. 2, H.D. 1, C.D. 1 asked the State Auditor to conduct an audit of the child protective services system.

We found that DHS has not ensured that all child abuse and neglect reports are investigated when appropriate. Supervisory review at key decision-making points has been insufficient and staff have failed to follow established procedures to assess the risk of harm when receiving and investigating reports of suspected abuse and neglect.

We reviewed 112 cases statewide that were not referred to investigation and were unable to confirm DHS' supervisory review for 88 percent of these cases. Statewide, supervisory review was documented in only 5 percent of the investigated dispositions we reviewed. In a sample of written reports made by individuals who are legally mandated to report suspected abuse and neglect, we found that 13 percent of these reports were not identified on the DHS intake logs and in the Child Protective Services System (CPSS), DHS' central registry of abuse and neglect reports.

We also found that the DHS' communication within its Child Welfare Services Branch and with the county police and the Family Court is ineffective. As a result, DHS has not ensured that decision makers have access to necessary information, that criminal proceedings begin when warranted, or that Family Court jurisdiction is sought when required.

Nearly half of the child abuse and neglect cases reported statewide during June 1998 were not registered in the CPSS. This limits communication within the department and does not assure that the risk of harm will be considered during key decision making. In a one-month period that we reviewed, DHS failed to refer to the county police about 40 percent of the reports of child sexual assault that it received. Also, the police do not consistently inform DHS of all child abuse and neglect cases reported to the police.

DHS has also been remiss in its obligation to seek Family Court jurisdiction when required. Also, DHS has allowed children to remain in foster custody without proper legal authority.

We also found that DHS and Family Court emphasis on family reunification exceeds federal requirements. The case files contained a number of court-ordered service plans that duplicated previously ordered services to families who were

either unwilling or unable to complete the services. Duplicating service plans detracts from child protection and increases foster care costs unnecessarily.

We also found that DHS' weak management of its contracts with private organizations serving abused and neglected children and their families does not assure that services paid for are received and effective. For example, in a sample of contracts we found that $180,000 could have been saved if DHS had adjusted its contracts with private providers to correlate with utilization levels.

Together DHS and the Family Court have made significant progress to increase federal reimbursements for foster care under Title IV-E of the Social Security Act. However, we found DHS could make additional improvements through more timely eligibility determinations. DHS could also improve the accuracy of its reimbursement claims. We also found DHS has not established sufficient management controls to ensure that foster care payments end when a child leaves a foster home and to prevent overpayments to families receiving general assistance payments when a child is placed in foster care. Furthermore, DHS has not sufficiently identified and tracked foster care overpayments.

Recommendations and Responses

We recommended that DHS establish sufficient management controls to ensure that all child abuse and neglect reports are investigated as appropriate. We made recommendations for improving communication between DHS' Child Welfare Services Branch, the county police, and the Family Court.

We recommended that both DHS and Family Court move for permanency hearings when families are unwilling or unable to comply with appropriate and available services. We also recommended amendments to Chapter 587, HRS, to clarify that permanency planning begin 12 months after a child's placement in foster care. Also, DHS should improve its management of contracted services; improve its ability to capture all available Title IV-E funds and accurately claim administrative reimbursements; and improve its management of various payments related to child protection.

DHS responded that as a whole, it concurs with our findings and recommendations. The Judiciary responded that it plans to disseminate to all Family Court judges the recommendation that we directed to this court. The Honolulu and Hawaii police departments described some of their child protection activities.

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Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 99-5
January 1999

Foreword

This report of our audit of the child protective services system was prepared in response to Senate Concurrent Resolution No. 146, Senate Draft 2, House Draft 1, Conference Draft 1 of the Regular Session of 1998. The resolution requested that the audit focus on decision-making processes and communications related to child protective services.

We wish to express our appreciation for the cooperation and assistance extended to us by officials and staff of the Department of Human Services, the Department of the Attorney General, the Family Court, the county police departments, and others whom we contacted during the course of the audit.

Marion M. Higa
State Auditor

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Chapter 1
Introduction

Hawaii's child protective agencies are charged with protecting children from abuse and neglect. Several state and county agencies share responsibility for implementing and administering child protective services. These state and county agencies include the Department of Human Services, the Department of the Attorney General, the Family Court, and the four counties' police departments.

Recent criticism of poor interagency communication and decision-making processes, together with legislative concern that family reunification efforts precede a child's safety, led the 1998 Legislature to ask the State Auditor to conduct a program audit of the child protective services system. Senate Concurrent Resolution No. 146, Senate Draft 2, House Draft 1, Conference Draft 1, requests that the audit focus on the decision-making processes and communications related to child protective services at the Department of Human Services, the Department of the Attorney General, the Family Court, and the county police departments. The Legislature also requested that the Auditor make specific recommendations to guide the reform and design of an effective child welfare system.

Background on Child Protective Services

Chapter 350, Hawaii Revised Statutes (HRS), defines child abuse or neglect as an act or omission by any person or legal entity related to, residing with, or otherwise responsible for the care of a child that results in physical or psychological harm or risk of harm to a child under age 18. Child abuse and neglect can include physical injuries such as fractures, burns, internal bleeding, and bruising; psychological abuse manifested as extreme mental distress; failure to thrive as the result of medical neglect or the inadequate provision of food, clothing, and shelter; providing harmful drugs to a minor without prescription; and sexual abuse.

Since 1967, the Department of Human Services has maintained a central registry of reported incidences of child abuse and neglect. The registry is maintained by the department's automated Child Protective Services System (CPSS). During 1997, the department investigated 5,235 cases of alleged abuse and/or neglect and confirmed about 50 percent of the reported cases. Physical abuse was the most prevalent type of abuse confirmed during 1997, as shown in Exhibit 1.1. Since 1996, the department has investigated about 5,000 reports a year of suspected abuse and/or neglect. About 50 percent of the reports investigated were confirmed, both statewide and by county, except for the county of Kauai, where confirmations were 30 to 40 percent.

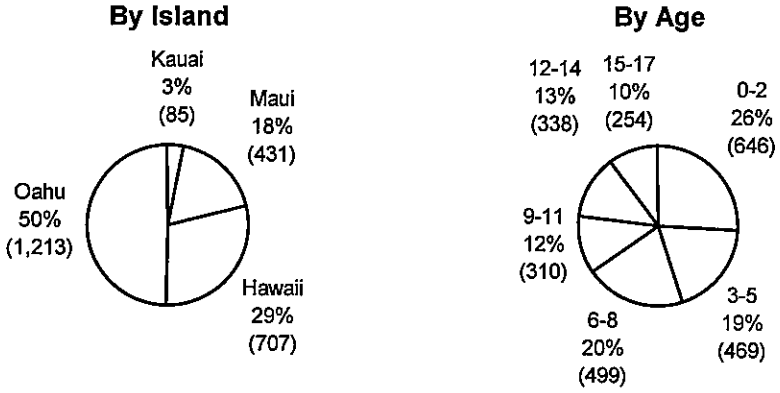
Exhibit 1.1
Child Abuse and Neglect Reports Investigated and Confirmed, Calendar Year 1997

Type of Abuse	Number of Reports Investigated	Number of Reports Confirmed	Percent of Reports Confirmed
Physical	2,165	1,122	52%
Neglect	1,630	776	48%
Physical & Neglect	1,004	448	45%
Sexual	436	185	42%
Statewide Total	5,235	2,531	48%

Source: Department of Human Services Information Systems Office, *A Statistical Report on Child Abuse and Neglect in Hawaii, 1997*, p. 6.

Oahu had the highest number of confirmed child abuse and neglect reports investigated. The greatest number of statewide confirmed cases involved children under the age of one. Exhibit 1.2 shows the number and percentage of abuse and neglect reports the department confirmed by island and by age group.

Exhibit 1.2
Confirmed Child Abuse and Neglect Reports by Island and Age, Calendar Year 1997



Source: Department of Human Services Information Systems Office, *A Statistical Report on Child Abuse and Neglect in Hawaii, 1997*, pp. 7-10, 17.

To protect children from harm, Chapter 350, HRS, *requires* that individuals in certain professions immediately report to the Department of Human Services or to the county police departments what they believe to be actual abuse or neglect or a substantial foreseeable risk of abuse or neglect. Individuals mandated to report abuse and neglect include school employees, health professionals, law enforcement employees, and employees of public and private agencies providing financial assistance. These mandated reporters were the source of about 46 percent of all reports of abuse and neglect investigated by the Department of Human Services during 1997. The law also *permits* others—that is, nonmandated reporters—to make reports.

Significant State and Federal Resources Are Involved

About $46 million in state and federal funds were appropriated to the Department of Human Services for child protective services during FY1997-98: $29 million in general funds, $17 million in federal funds, and $100,000 in special funds. Exhibit 1.3 shows the types of appropriations.

Exhibit 1.3
Legislative Appropriations to the Department of Human Services for Child Protective Services, FY1997-98

Source of Funds	Amount Appropriated (Act 328, 1997)
General	$29,240,773
Federal	
Title IV-B	$1,963,548
Title IV-E	9,599,907
Title XX	4,987,658
Child Abuse Prevention and Treatment Act (CAPTA)	130,215
Other	609,089
	$17,290,417
Special	100,000
	$46,631,190

Note: The item on Title IV-E appropriations excludes $1,424,000 appropriated to the Department of Human Services but disbursed to the Department of Health.

The department's annual appropriation for child welfare services includes funds for contracted services and reimbursements to the attorney general for child protection services. During FY1997-98, the department spent over one-third of its appropriations for contracted services and foster care payments.

Other state and federal funds for child protection, which are not included in Exhibit 1.3, are expended by the Family Court and the Department of Health; however, these departments' budgets do not distinguish the amounts allocated for child protection.

As shown in Exhibit 1.3, the department receives federal funds through Titles IV-E, IV-B, and XX of the Social Security Act. Title IV-E provides funds for children who are in foster care as a result of child abuse or neglect and are eligible based on family income level and other criteria at the time of removal from the family. Title IV-E also provides funds to families adopting special needs children and to teens who have reached the age of majority and remain in school or job training. Title IV-B funds provide families with treatment services that promote reunification or maintain a child in a safe family home. Title XX, the Social Services Block Grant, also provides families with needed services.

The department also receives basic state grants through Title I of the federal Child Abuse Prevention and Treatment Act (CAPTA). These funds are designated for the investigation of child abuse and neglect complaints and to provide families with services.

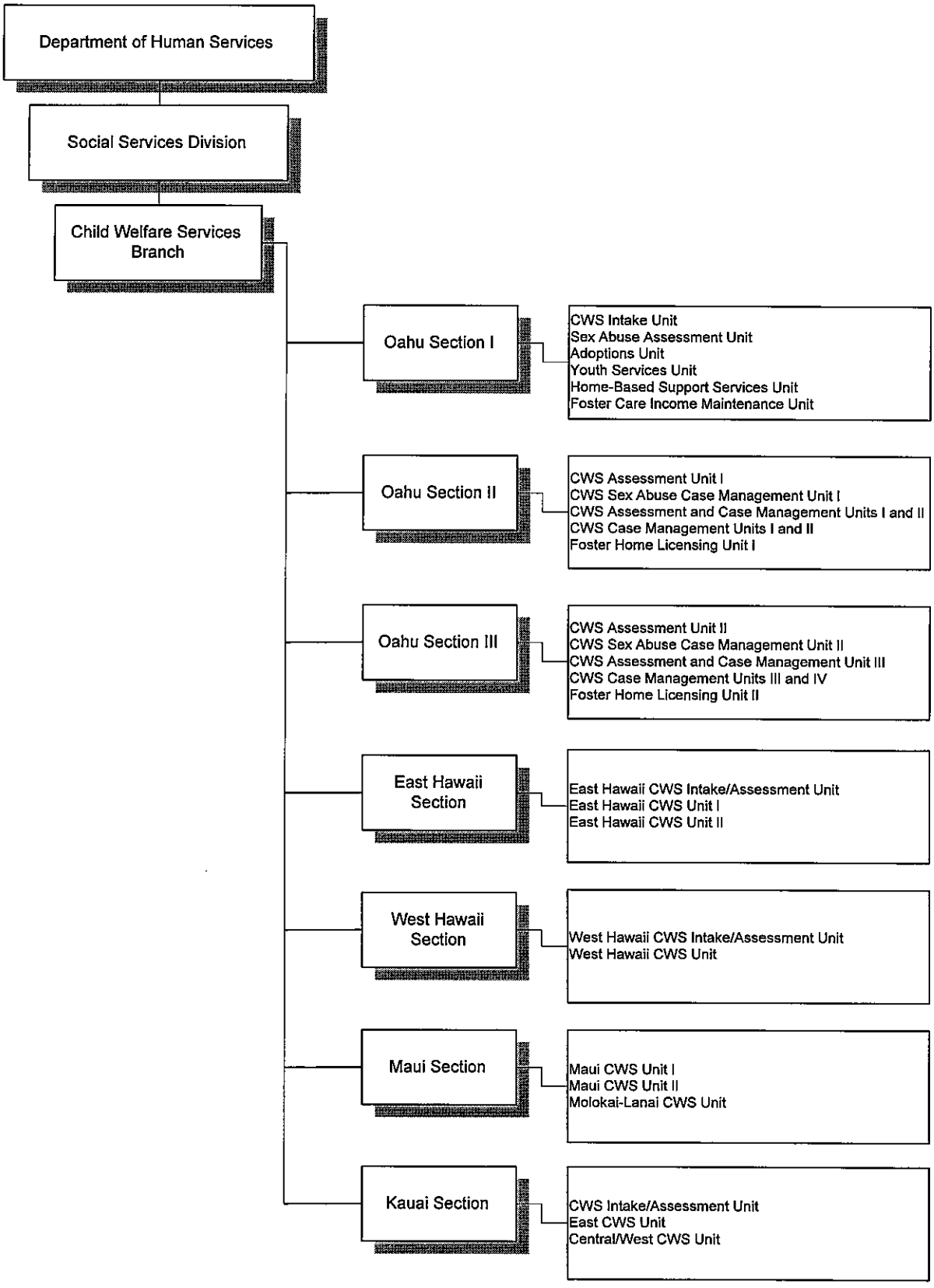
Department of Human Services is the lead agency

Section 346-14, HRS, makes the Department of Human Services the lead agency for establishing, extending, and strengthening services for the protection and care of neglected children. The department's Child Welfare Services Branch focuses on child protection, foster care, and adoption services to protect the safety and well-being of children and to assist in placing children in permanent safe homes.

The Child Protective Act, Chapter 587, HRS, makes the department responsible for investigating reported cases of abuse and neglect, assuming temporary foster custody of children as necessary, and petitioning the Family Court for child protective cases. About 400 staff in the Child Welfare Services Branch help fulfill these responsibilities.

Statewide, the child welfare branch's 7 sections and 37 units employ about 230 social workers and an additional 110 social services assistants and family service assistants who help provide home-based services. The average caseload for each social worker (excluding supervisors) ranges from 16 cases in East Hawaii to 20 on Kauai. The median caseload is 18. The branch also employs income maintenance workers who identify Title IV-E eligible children placed in foster care on Oahu and Hawaii. Exhibit 1.4 shows the organizational structure of the Child Welfare Services Branch.

Exhibit 1.4
Organization of Child Protective Services in the Department of Human Services



The Child Welfare Services Branch also provides children and their families with contracted services, including emergency shelters, individual and family counseling, sex abuse treatment, and home-based and outreach services. These services are often required by court-ordered service plans directed at facilitating the return of the child to or the maintenance of a child in a safe family home. The department also contracts multidisciplinary teams to perform case reviews and assist with assessing the risk of harm and protective options for the child.

Interagency roles and responsibilities

Other key agencies work with the Department of Human Services from case intake through case closure. These agencies include the county police departments and prosecutors, the Department of the Attorney General, and the Family Court. The role of each of these agencies is included in Exhibit 1.5.

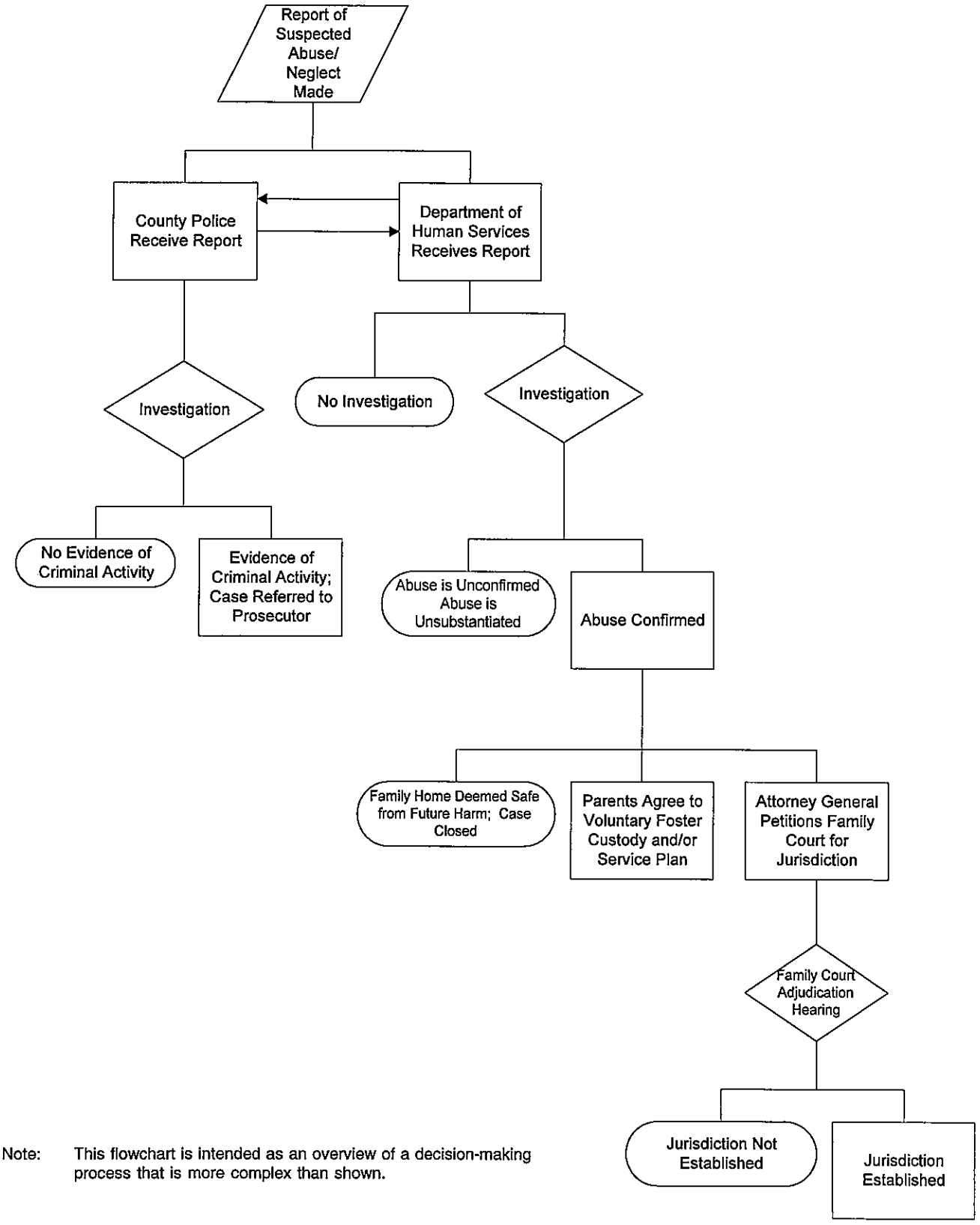
County police respond to reports received of abuse and neglect and inform the Department of Human Services of these reports as required by Hawaii's mandated reporting law. Section 587-22, HRS, authorizes the police to take protective custody of a child deemed to be in imminent harm in the absence of either a court order or family consent. Upon taking protective custody of the child, the police are required to immediately transfer temporary custody to the Department of Human Services.

County prosecutors decide whether parents will be criminally charged in child abuse and neglect cases; however, the responsibility for petitioning courts for the child's removal from the family home and for establishing a court-ordered service plan remains with the Department of Human Services.

The role of the Family Court is set forth in Section 587-11, HRS (Jurisdiction), Chapter 571, HRS (Family Courts); and other statutes. Judges on the islands of Oahu, Hawaii, Maui, and Kauai hold several types of hearings in Family Court related to child protection. They hold temporary foster custody hearings within two days of receiving a petition to determine whether a child should remain in out-of-home placement or be returned to the family. Return and adjudication hearings decide the jurisdiction over a child. The court reviews department reports assessing the safety of a family home when determining whether harm or the risk of harm exists and whether court jurisdiction over the child is required.

Dispositional hearings allow the court to review the appropriateness of the placement of a child and the family service plan developed to address the family's problems. The court also conducts review hearings every six months for each child under its jurisdiction to review the appropriateness

Exhibit 1.5
Some Key Decision-Making Points in Child Protective Services



Note: This flowchart is intended as an overview of a decision-making process that is more complex than shown.

of the placement and the plan. At these hearings the court may order changes in the placement or plan. At permanent plan hearings, the court decides whether to terminate parental rights. The average number of cases before the court is about 3,000. Each case takes an average of two to three years.

The Department of the Attorney General represents the Department of Human Services for all court petitions filed. The attorney general also represents the department in lawsuits filed against the State for placing a child in foster care where harm occurred and for failing to remove a child from a home where harm is imminent. Over the past five fiscal years, the State settled seven of these lawsuits with complainants for $781,000. An additional $2,601 was paid to a foster parent who suffered injuries in his role.

Recent Federal Reforms Emphasize Child Protection over Family Reunification

Key to child protective programs is the belief that children belong with their families and should remain or be reunified with them when at all possible. State courts are required to make determinations that reasonable efforts have been made for reunification so that children can be eligible for Title IV-E support. However, recent changes to federal and state child protection laws clarified that the children's safety is paramount and that permanency planning can take place earlier when certain criteria are met.

Reasonable efforts to preserve and reunify families are no longer uniformly required

The federal Adoption and Safe Families Act of 1997 reaffirmed the importance of making reasonable efforts to preserve and reunify families. However, the act also exempts state courts from making a determination of reasonable reunification efforts when specific circumstances exist. These include aggravated circumstances as defined in state law; cases in which parents have committed murder or voluntary manslaughter, conspired to commit murder or manslaughter, or committed felony assault of another child of the parent; or cases in which parental rights to another sibling were terminated involuntarily.

Early permanency planning is a state and federal priority

The Adoption and Safe Families Act also decreased the time frame in which a case must be set for permanency planning from 18 to 12 months from the time a child is placed in foster care. These changes were reflected in Act 134, SLH 1998, and can affect the disposition of child protective services.

Previous Reports

We previously contracted with the National Child Welfare Resource Center for Management and Administration at the University of Southern Maine to conduct a study of foster care in Hawaii. The resulting report, *Study of Foster Care in Hawaii*, February 1990, found that Hawaii could increase the amount of Title IV-E funding it received by establishing a system to document the eligibility of individual children for foster care and adoption assistance. Specifically, the report found that the Family Court had not made many determinations on the department's reasonable efforts to prevent foster care placement, resulting in lost eligibility for federal funds. The report also noted that the Department of Human Services was not receiving all federal funds available for adoption assistance because it failed to document whether adopted children met financial eligibility requirements.

Our foster care study also noted that the department contracted with private providers for the placement of children in foster homes and assumed all monthly board and care costs without monitoring these placements. We also reported poor contract management by the department in our studies of its family preservation efforts. Our *Study of Family Preservation Services and the Families Together Initiative*, Report No. 94-2, found that the department had allowed private providers to develop and implement assessment tools for determining the effectiveness of their own services. Our final report on this program, Report No. 95-6, also noted that the department needed to improve its ability to monitor the success of its family preservation services.

Our *Management Audit of the Department of Human Services*, Report No. 97-18, reported that the foster board payment program was being administered with little regard for fiscal constraints. We found that expenditures for services, other than flat monthly board payments, were made largely at the discretion of individual social workers.

Objectives of the Audit

1. Determine the adequacy of decision-making processes and communication in the child protective services system from case intake through closure.

2. Assess whether the Department of Human Services' management of contracted services ensures that abused and neglected children and their families in the child protective services system receive needed services in a cost-effective manner.

3. Assess whether the Department of Human Services has established sufficient management controls in the child protective services

system to identify and receive available federal Title IV-E funds for abused and neglected children, and to ensure proper payments for foster care, adoption assistance, and independent living.

4. Make recommendations as appropriate.

Scope and Methodology

Our audit assessed the adequacy of the decision-making processes from case intake through case closure after a report of suspected child abuse and/or neglect is made to the Department of Human Services under the Child Protective Act, Chapter 587, HRS. We also reviewed the roles of the Department of the Attorney General, the Family Court, and the county police, as applicable in case intake, investigation, management, and closure.

We reviewed pertinent state and federal laws, interviewed staff from each of the agencies included in our review, and reviewed case files and police reports for both open and closed cases. We also interviewed staff from key national child abuse programs, including the National Conference of State Legislatures Child Protection Reform Project, the National Resource Center of Child Maltreatment, and the Child Welfare League of America.

Our review of contracted services included contracts effective July 1, 1997 through June 30, 1998. Our review of foster care, adoption assistance, and independent living payments was limited to FY1997-98 and FY1998-99 (through September 30, 1998).

Our work was performed from June 1998 through January 1999 in accordance with generally accepted government auditing standards.

Chapter 2

Key Child Protection Activities and Related Financial Costs Need Better Management

Balancing child protection, parental rights, and family unity is an arduous task for agencies entrusted with protecting children from abuse and neglect. Although worker judgment and knowledge cannot and should not be excluded from the key decision-making processes, sufficient management controls must be established to reduce the risk of harm and serious consequences that may result from errors in individual judgment. Sufficient controls are also needed to ensure that resources designated for child protection are efficiently used to protect children from future harm and to reunite families when appropriate.

The operation of the child protective services system depends on the efficient and effective communication and decision-making among the Department of Human Services, Department of the Attorney General, the Family Court, and the county police departments. We found that communication between some of these agencies is poor and that policies delineating standards for decision making are not always followed. These conditions increase the risk of harm from abuse and neglect. Furthermore, weak contract management and poor fiscal controls can leave clients unserved and waste resources.

Summary of Findings

1. The Department of Human Services has not established sufficient management controls to ensure that all child abuse and neglect reports are investigated when appropriate. Consequently, intake workers and investigators are allowed to arbitrarily disregard abuse and neglect reports and to close cases prematurely.

2. The department's communication within its Child Welfare Services Branch and with the county police and Family Court is ineffective. As a result, the department has not ensured that decision makers have access to necessary information, that criminal proceedings begin when warranted, or that Family Court jurisdiction is sought when required.

3. The department's and the Family Court's emphasis on family reunification goals exceeds federal requirements, thereby increasing foster care costs. The Child Welfare Services Branch's mission has been expanded to include adult rehabilitation and detracts from its primary purpose of child protection.

4. The department's weak contract management does not assure that services paid for are received and effective.

5. The department's efforts to identify and receive available federal Title IV-E funds have improved significantly. However, improvements in eligibility determination are needed to ensure that available federal funds are claimed and administrative reimbursements are accurate.

6. The department has not established adequate management controls to ensure that foster care payments end when a child leaves a foster home and to prevent overpayments to families receiving general assistance payments when a child is placed in foster care. Furthermore, the department has not sufficiently identified and tracked foster care overpayments.

Reports of Alleged Child Abuse and Neglect Are Sometimes Arbitrarily Disregarded in the Department of Human Services

The Department of Human Services has not established sufficient management controls to ensure that all child abuse and neglect reports are investigated when appropriate. Supervisory review at key decision-making points has been insufficient and staff have failed to follow established procedures to assess the risk of harm when receiving and investigating reports of suspected abuse and neglect. As a result, abuse reports requiring a response within 24 hours have not always been investigated in a timely manner or at all. Furthermore, the department's disposition of unconfirmed abuse reports is sometimes questionable.

Supervisory review of key decisions is insufficient

Supervisory review of key decisions ensures that no single individual is allowed to make decisions arbitrarily. Case intake and investigation are two critical points at which Department of Human Services staff make crucial decisions.

Although the department's procedural manual requires supervisors to review all reports of abuse and neglect that are not referred to investigation and to review the dispositions of those cases referred to investigation, we generally found no evidence to indicate compliance with these review policies. Management controls to ensure supervisory review of intake staff's decisions do not provide adequate assurance that cases warranting investigation are not prematurely dismissed. Moreover, the department's failure to document all reports of abuse and neglect, together with untimely investigative dispositions, inhibits supervisory review.

Management controls for case intake are inadequate

Intake staff serve as child protective services "gatekeepers" by deciding whether a report of suspected abuse or neglect will be sent to investigation. In order to ensure objective decision making by intake staff, the department's procedural manual requires that all reports not referred to investigation be submitted for supervisory review. The supervisor's decision to override the intake worker's recommendation of no referral to investigation must be documented on the intake log. However, each intake supervisor has replaced this requirement with various other review procedures.

For example, the practice of the Oahu intake supervisor is to review reports not referred to investigation when she updates the reports' statuses in the Child Protective Services System (CPSS) from "pending" to "active" or "inactive." CPSS is the department's automated central registry of abuse and neglect reports required by Chapter 350, Hawaii Revised Statutes (HRS). We found this supervisor's practice to be insufficient because Oahu's intake staff did not record in the CPSS over half of the reports not referred for investigation. Furthermore, no special authority is needed to update the status of a report documented in CPSS, and no control exists to keep workers from disposing of cases themselves. This laxity could enable workers to bypass supervisory review. The lack of controls has statewide implications because at the time of our field work the department was considering centralizing all intake reports on Oahu.

Some intake supervisors document their review by signing the intake reports. Other intake supervisors do not even document their review.

Currently, supervisors are not required to document their review of cases not referred to investigation when they agree with the intake worker's decision. Consequently, supervisory review cannot always be confirmed. We reviewed 112 cases statewide not referred to investigation and were unable to confirm supervisory review for 88 percent of these cases. Documentation indicating that supervisory review of such reports had occurred ranged from a high of 47 percent in one unit to a low of 5 percent in another unit. Consequently, reports warranting further review by the department may have been prematurely dismissed during case intake.

When supervisory review does occur, these cases can be identified and investigated by the department. For example, after a supervisory review, the Hilo intake supervisor referred to investigation one-fifth of the reports not initially referred to investigation by the intake worker.

The department does not account for all reports of abuse and neglect

Intake staff who receive reports of abuse and neglect account for each report on an intake log. If followed, this procedure ensures that the department tracks the number of abuse reports accurately and is held accountable for deciding whether to investigate each reported case. However, we found intake workers do not routinely log all reports of abuse and neglect, thus hindering both accountability and supervisory review.

We obtained 45 written reports made by mandated reporters statewide and found that 13 percent of these reports were not identified on the department's intake logs and in the CPSS. Furthermore, several mandated reporters informed us that when they attempted to make reports of suspected abuse or neglect as required by Chapter 350, HRS, the department refused to accept their reports.

Although Chapter 350, HRS, allows the department to determine which reports of abuse and neglect it will investigate, Title 17 of the Hawaii Administrative Rules requires the department to accept all reports of abuse and neglect, assess the validity of the reports, and provide appropriate services as applicable. The department's failure to log all reports discourages individuals from reporting suspected abuse and neglect and makes supervisory review of these cases impossible.

Untimely investigations hinder supervisory review

The department's investigators review reports of suspected abuse or neglect and decide whether enough evidence exists to confirm that the abuse or neglect occurred. A report of abuse or neglect may not be confirmed under the following circumstances: the report was not referred to investigation; the investigator was unable to clearly determine that abuse or neglect did occur; there was clear evidence that abuse or neglect did not occur; or the report was made in bad faith and was therefore unsubstantiated. The outcome of an investigation is key because it can result in the department either offering (or referring the family to) intervention services and/or closing the case. The department requires investigative supervisors to review and document their agreement or disagreement with each investigative disposition.

Title 17 of the Hawaii Administrative Rules requires that the department make a clear decision within 60 days of the intake report date as to whether abuse or neglect occurred. The disposition must be clearly stated in the department's records and shared with the reporting party, family, and alleged perpetrator.

Supervisors of three Oahu investigative units provided us with their reports of cases pending investigation for their respective units. Upon reviewing the reports, we found that 80 percent of the pending cases were over 60 days outstanding. Many cases were over a year old. Some cases were several years old; one case dated as far back as 1993. A social worker informed us that case closings are a social worker's last priority, following emergency room/hospital cases, court cases, and transfers to case management, respectively.

The untimely disposition of investigations hinders supervisory review, which occurs after the investigator makes a disposition and either transfers the case to case management, petitions the Family Court, or closes the case. We also found that dispositions are generally not shared with the reporting party as the rules require.

Statewide, despite the importance of investigative dispositions, supervisory review was documented in only 5 percent of the dispositions we reviewed.

Assessment of risk of harm is arbitrary

Title 17 of the Hawaii Administrative Rules requires the department to use a risk assessment matrix in each case to evaluate the urgency of the department's response, the risk of future harm, and the continuing need for departmental intervention during investigation and case management. The matrix is intended to ensure that social workers thoroughly and consistently collect and organize the known facts about each report.

However, staff on the islands of Oahu, Hawaii, and Kauai generally did not refer to any standardized criteria when making key decisions, including whether to refer a report to investigation and whether abuse or neglect occurred. At the time of our fieldwork the department's procedural manual did not specifically require that staff use a risk assessment matrix. Consequently, most staff relied solely upon their "individual judgment," which sometimes resulted in reports of sexual abuse not being investigated and questionable dispositions of unconfirmed abuse.

The department recently piloted the use of a risk assessment matrix during case intake, investigation, and case management on Maui and has since required its use on a statewide basis effective October 1, 1998. However, the statewide implementation of the risk assessment matrix does not assure standardization when staff assess the risk of harm since the department only requires its use in specific circumstances. These circumstances include risk assessment during intake for cases involving children age five and below, and when the investigation of a case is completed. In Maui's pilot program, we found staff did not consistently and properly use the matrix.

Reports of sexual abuse are not always investigated

A unit supervisor we interviewed informed us sexual abuse is considered to be one of the most serious forms of child abuse. Department policy requires that reports of sexual abuse be responded to immediately. We reviewed reports of suspected sexual abuse and believe the department sometimes did not refer a report to investigation that warranted an investigation.

One report alleging an aunt had molested her minor nephew warranted further investigation. However, the intake social worker and intake supervisor agreed the case would not be referred to investigation on the premise that the aunt was not the primary caregiver of the child. We believe this case should have been referred to investigation, since Chapter 350, HRS, defines child abuse to include sexual abuse by *any person* who is in *any manner or degree* related to the child. Had the department investigated further, a background check on the aunt would have revealed that as a child, she had been under the child protective services' jurisdiction as a victim of sexual assault.

Whenever the department receives a report of sexual assault, it should routinely inform the county police even if the abuse does not fall under the statutory definition of child abuse. Administrative rules require the department to inform the police or prosecutors of all reports involving possible criminal activity. This would help protect sexual abuse victims from further abuse.

Unconfirmed abuse dispositions are questionable

The department has not confirmed that abuse or neglect occurred in about 50 percent of all reports it has investigated annually since 1996. However, we question the department's determination of "unconfirmed" dispositions for several reports we reviewed.

In one report, a mother admitted that she caused the bruises on her child by hitting the child with an object; however, the investigating social worker believed that the incident was isolated and decided that abuse was unconfirmed. Despite the mother's admission and the fact that the injuries were significant enough to cause the child to limp for two days, the case was determined "unconfirmed." Eight months later, the mother similarly abused the child's sibling. Once again the mother acknowledged that the incident took place; however, abuse was confirmed to have occurred this time. A different investigator assigned to the case confirmed that the abuse had occurred.

Implementation of risk assessment matrix needs improvement

The department's efforts to improve decision making through the use of risk assessment tools is commendable. The efficiency of an assessment matrix, however, depends on needed improvements. Staff must consistently use it at critical points of decision making and understand how to interpret the results.

On Maui, where the risk assessment matrix was piloted, staff did not consistently use the matrix. Of the cases we reviewed, it was used in 89 percent of the cases during case intake but in only 30 percent of the cases during the investigation.

We also found that staff did not always complete the matrix accurately during case intake. In some cases, the information from the intake form and/or the family's past child protective services history did not correlate with the completed matrix. For example, an intake social worker indicated that a family history of abuse and neglect was moderate, yet past confirmed reports identified the risk as high.

The matrix involves a process referred to as "clustering." Clustering involves grouping specific and identifiable risk factors into low, medium, high, and severe risk categories. The completed matrix is a graph that incorporates the information gathered on a form to determine the cluster levels for harm, vulnerability, caretaker's ability to protect the child, and past history of the caretaker.

However, the effectiveness of the matrix has been limited due to the lack of guidance on how to cluster and interpret the matrices. Maui staff did not cluster any of the risk factors to determine overall risk or safety assessments for the various categories. As a result, staff used their individual judgment to assess degree of risk.

Communication Involving the Department Is Inadequate

The Department of Human Services' ineffective communication within its Child Welfare Services Branch and with the county police and Family Court has not ensured that decision makers have access to necessary information. Moreover, the department's failure to communicate all reports involving possible criminal activity to the police provides no assurance that criminal proceedings will begin when warranted. Finally, the department's weak oversight over children placed in voluntary foster custody and of families receiving child protective services under voluntary agreements does not ensure that cases requiring Family Court jurisdiction are brought to the attention of the courts.

The department's child abuse and neglect data base is unreliable

Although the Hawaii Administrative Rules require that every child abuse or neglect report be registered in the State's central registry for child abuse and neglect incidents (CPSS), nearly half of all the child abuse and neglect cases reported statewide during June 1998 were not registered in the CPSS. Chapter 350, HRS, requires the department to promptly expunge reports when they are either unsubstantiated or the report is dismissed by the Family Court. However, both state and federal laws do not preclude the department from retaining records of alleged abuse and neglect for use in future risk and safety assessment. The department informed us that it had not expunged any records from the CPSS as of the time of our fieldwork; therefore, expunging cases is not the cause for the incomplete records within the CPSS.

The procedural manual for child protective services states that a CPSS clearance and central registry background check is routinely completed for each report of abuse or neglect in order to provide history and case information that may be pertinent to the risk assessment of the child. The department's failure to document all cases in the CPSS limits the department's intraagency communication and does not assure that the risk of harm will be considered during key decision making.

Furthermore, the untimely completion of intake reports limits the potential of the CPSS to be a source of accurate and up-to-date information. Moreover, intake staff do not routinely screen new reports of abuse and neglect for CPSS case history. We randomly selected intake reports received between January and June 1998 and found that background checks were documented in only 43 percent of these reports. We searched the CPSS for prior case histories for these reports and documented that a prior case history existed for more than half of the cases.

Communication between the department and the county police needs improvement

Title 17 of the Hawaii Administrative Rules requires that the department refer all reports in which criminal activity may have occurred to the county police or county prosecutors. The rules require that interagency agreements between the department and county police outline cases involving criminal activity. At the time of our fieldwork the department had signed interagency agreements only with the Honolulu and Kauai county police. However, the department's written agreement with the Kauai police does not ensure that all cases involving criminal activity will be reported to the police. The agreement only requires the department to refer all cases the department investigates to the police.

The agreements with the Honolulu and Kauai county police also state that the police will inform the department's child protective services staff of any child abuse or neglect report that comes to police attention. Furthermore, Hawaii's mandated reporting law requires each county police department to report all cases of suspected abuse and neglect to the department.

In addition to these cross-reporting requirements, the county police departments, Children's Advocacy Center (an organization attached to the Judiciary whose purpose is to maintain cooperation and case management in child sex abuse cases), and the Department of Human Services have written agreements encouraging joint investigations and interviews in sex abuse cases statewide.

Despite these cross-reporting requirements and agreements, we found that the police are not always informed of all child abuse and neglect cases that may involve criminal activity. During July 1998, about one-third of these cases on Oahu and half of the cases on Maui were not reported to the police. The intake logs for the remaining islands did not provide enough information to allow us to identify cases involving possible criminal activity. However, we were able to identify the sexual assault reports received by each of the State's intake units during July 1998 and found that about 40 percent of these reports were never referred to the county police.

The department should standardize interagency cross-reporting agreements to ensure consistency when referring to the police. The agreements should ensure that all reports involving possible criminal activity are referred to the county police as required by administrative rule. The Legislature should also consider strengthening Chapter 350, HRS, to identify those reports received by the department that should be referred to the police. The National Center on Child Abuse and Neglect (NCCAN) reports that legislatures in 13 other states have required child welfare agencies to refer all reports they receive to the police. Laws in other states require child welfare agencies to refer to the police any reports meeting certain criteria such as serious abuse or sexual abuse.

The county police also do not consistently inform the department's child protective services of all child abuse and neglect cases reported to the police. We found that the police communicated to the department only a little more than half of the reports they received during the one month periods we reviewed.

Inadequate communication between the Department of Human Services and the county police does not ensure that families requiring intervention services are being served or that criminal investigations are commencing when warranted.

Court jurisdiction is not always sought in a timely manner

When a family is either unable or unwilling to make the family home safe, the department must communicate with the Family Court to ensure court jurisdiction. Family Court jurisdiction is required when children placed in voluntary foster custody are not returned to a safe family home within 90 days, as required by Title 17 of the Hawaii Administrative Rules or when children whose parents agreed to voluntary services are not returned to a

safe family home within six months, as required by Chapter 587, HRS. Family Court involvement can result in court-ordered service plans, court-ordered foster custody, or termination of parental rights when deemed necessary.

The department has been remiss in its obligation to seek Family Court jurisdiction when required. In our review of a sample of children voluntarily placed in foster custody, we found that 53 percent remained in voluntary placement beyond 90 days. These placements exceeded the 90-day limitation by anywhere from one day to over three years. Yet the department did not petition the Family Court in a timely manner for any of these cases.

We also found the department does not adequately oversee families who consented to voluntary service plans in order to ensure, as the Child Protective Act requires, that the court is petitioned when the family does not successfully complete the plan within six months. We reviewed nine cases involving voluntary service plans and determined that the department did not comply with this policy in five, or 56 percent, of the cases.

Inadequate oversight of children placed in voluntary foster custody places the State at risk of liability

Chapter 587 authorizes the department to place a child in foster custody without court order only when the parents or guardians voluntarily consent to foster custody placement or when the department places a child in temporary foster custody for a maximum of three days prior to petitioning the court for custody.

When parents or guardians consent to foster custody, an agreement indicating the dates the child may remain in custody is signed and dated by the department and the parents. This consent agreement protects the department against claims of improper removal of a child from the family home.

The department does not sufficiently monitor the consent agreements signed by parents to protect itself against false claims of removal. In some cases, the department allowed the agreement to expire without returning the child to the home or petitioning the court for jurisdiction. In one case, the department did not have a completed agreement on file for a child who had been removed from the family home and had been in foster custody for eight months at the time of our review.

The monitors for the department's Title IV-E program also determined that social workers allow voluntary foster custody agreements to lapse without judicial intervention and renegotiation. The Social Services Division administrator required a corrective action plan; however, neither

the division administrator nor the Child Welfare Services Branch administrator could identify the resulting corrective action to us. When we obtained the corrective action plan from a section administrator, we found it to be vague. It did not specifically address how controls would be implemented to prevent children from being placed in foster custody without proper authority. Consequently, the department continues to maintain children in voluntary foster custody without legal authority.

Department and Family Court Emphasis on Reunification Exceeds Federal Requirements

The Social Security Act requires states to make reasonable efforts to prevent a child's removal from the family home and to reunify families when a child is placed in foster care. Although "reasonable efforts" is not specifically defined in federal law, the Code of Federal Regulations provides guidance in meeting the reasonable efforts requirements. The code requires that states include a description of the services offered and provided to families to prevent the removal of the child from the family home and to reunify the family. Federal law also makes the family courts responsible for determining whether states' child welfare agencies have made reasonable efforts to prevent foster care and to reunify families.

In service plans, signed by both the Department of Human Services and the parents, the department identifies the services it offers to families to prevent a child's removal or to reunify the family. However, we found that many case files contained a number of court-ordered service plans that duplicated previously ordered services to families who were either unwilling or unable to complete the services.

The practice of duplicating service plans increases foster care costs unnecessarily because children frequently remain in foster homes at a monthly cost of $529 per child while waiting for their parents to make the family home safe for their return. Many of these children are placed in a relative's home, where parents may have easy access to the child and therefore may be less motivated to comply with court-ordered services. In one case, the parents of a child placed with her grandparents lived in a parked car in front of the grandparents' home. When parental motivation is lacking, child safety is often displaced at the expense of efforts focused on reunification with and rehabilitation of parents who refuse services. This is unfair to the children and has resulted in delays in permanency planning within the time frames required by the federal government.

Services are offered to families unwilling and unable to complete services

Protecting children who are abused and/or neglected or who are at imminent risk of such harm is the mission of the Child Welfare Services Branch. The department seeks to achieve this purpose by providing intervention services and, when necessary, removing children from unsafe homes.

When a child is removed from the family home, the department offers services to the family to assist in reunification. Service needs vary by family and may include drug rehabilitation, parenting classes, and counseling. Although the department may offer services to a family, the use of these services often depends on the willingness and motivation of the parents. When parents are unwilling or unable to participate in available and appropriate services, the department and courts can move for permanency planning. However, we found that duplicative service plans are offered to families even when the families have refused to cooperate.

We reviewed 18 cases in which the courts had ordered families to participate in specified services. In about one-fourth of these cases, we found that the department and the Family Court continued to offer families duplicative service plans even though families made no efforts to complete the previously ordered services. In one case, a Hilo family was repeatedly offered drug treatment and parenting classes over a three-year period. The services were offered in seven separate court-ordered service plans despite the department's acknowledgment of the parents' noncompliance with services offered.

Families who fail to comply with court-ordered service plans may be found to be in criminal contempt of court, as authorized by Chapters 587 and 710, HRS. Criminal contempt of court may be treated as a misdemeanor (punishable by up to one year in prison and a fine of up to $2,000) or a petty misdemeanor (punishable up to 30 days in prison and a fine of up to $1,000). Although some judges informed us they have found noncompliant families in criminal contempt of court, most stated they prefer to remove the child from the family home or move for a permanency hearing. However, we found the courts have also been lax in this regard since we identified many noncompliant families who were given additional time in subsequent court-ordered service plans.

Permanency planning is untimely

Permanency plans must set forth as a goal either the adoption, guardianship, or permanent custody of a child. Until recently, federal and state laws required that permanency planning begin within 18 months following the month a child was placed in foster care or a year after a service plan had been court-ordered and the family home still determined to be unsafe. The federal Adoption and Safe Families Act of 1997 decreased the required time frame for permanency planning from 18 to 12 months in recognition that child safety is sometimes jeopardized by family reunification goals. Consequently, the federal government reaffirmed that children's health and safety must be paramount when making reasonable efforts for family reunification. Furthermore, the federal government allowed states the option of not applying the federal reasonable efforts requirement when aggravated circumstances as defined in state law are present.

The 1998 State Legislature defined "aggravated circumstances" to include parents who attempt, conspire to, or commit murder or voluntary manslaughter of another child of the parent; who commit felony assault resulting in serious bodily injury to the child or another child of the parent; or who have their parental rights involuntarily terminated. State law also provides that aggravated circumstances exist when a court has made a determination that the child's parents are not presently or in the reasonably foreseeable future willing or able to provide the child with a safe family home, even with the assistance of a service plan.

We found permanency planning has been hindered as the result of department-offered and court-ordered service plans that ignore the inability and/or unwillingness of parents to complete services that assist in making a safe family home. In one case, the department offered a family 11 service plans over 5.5 years before finally filing a permanency plan for adoption. We found three more cases in which the department and court did not move for permanency planning within the specified time period as required.

State Child Protective Act not in compliance with federal requirements

Until recently the Child Protective Act mirrored the federal requirement that a permanency hearing take place within 18 months of the date a child is placed in foster care. The federal Adoption and Safe Families Act of 1997 reduced the time period to 12 months. In 1998, the Legislature amended the Child Protective Act to reflect the federal change. In doing so, however, the Legislature made the 12 months optional rather than mandatory. To ensure compliance with federal requirements, the Legislature should amend the Child Protective Act to require permanency plan hearings within 12 months after a child's placement in foster care.

Department's Contract Management Is Weak

The Child Welfare Services Branch through its 47 contracts arranged for private organizations to provide needed services during FY1997-98 to abused and neglected children and their families, at a cost of $8.2 million. Some of the services provided included individual and family counseling, group treatment, sex abuse treatment, and emergency shelters. These services are intended to prevent future abuse and neglect, help maintain children in safe family homes, and assist in making safe the family home from which a child has been removed.

The department's commitment to providing needed services is shown by the significant portion of the child welfare services budget—about 18 percent—dedicated to contracted services. However, the department has failed to comply with monitoring provisions established in the Social Services Division's monitoring plan, resulting in weak contract

management. In addition, the progress of clients referred to contracted services is not always monitored as required by department policy. Consequently, there is no assurance that purchased services are effective. Furthermore, the department's failure to accurately account for clients receiving services results in little assurance that services paid for are in fact being received. We also found that the department does not consistently review the utilization of services for which it contracts, resulting in higher than necessary contract costs.

The department does not comply with monitoring requirements

Chapter 42D, HRS, establishes requirements for the purchase of services to ensure that the public purpose and legislative intent of each purchase of service is met. Chapter 42D requires that purchasing agencies develop a monitoring plan to include: (1) a comprehensive evaluation and monitoring manual, (2) quarterly progress reports to be completed by each provider, (3) an annual on-site visit to each program funded by the purchase of service agreement, and (4) an annual written report to be completed within 30 days of the site visit.

Although the Social Services Division of the Department of Human Services was able to provide us with a monitoring plan, we found the contract monitors did not adhere to the plan's monitoring requirements, resulting in the department's inability to ensure that public funds are well spent. This noncompliance may result partly from the unfamiliarity of the contract monitors and their supervisors with the monitoring plan. Twice we asked monitoring staff whether a written plan existed and twice the answer was no. Only at the close of our field work were the monitors able to provide us with a copy of the plan.

The department procedural manual also requires that social workers maintain contact with clients receiving services and assess their level of compliance with these services. However, we found the progress of clients receiving contracted services is not sufficiently monitored.

Site visits are not routinely completed, and annual reports are untimely

Annual site visits required under Chapter 42D, HRS, allow the department to obtain first-hand knowledge of a provider's services. We found, however, that the department did not visit half of the private provider sites in our sample of providers. Furthermore, we found that the department's annual reports describing the progress, compliance, and required corrective action for these private providers were not issued within 30 days of the site visit as required. These reports were submitted late anywhere from two weeks to over five months. The department's failure to monitor and report on areas requiring corrective action in a timely manner impedes needed change and promotes ineffective services.

The Legislature recently amended the state procurement law to establish a separate process for the purchase of health and human services. All contracts solicited or entered into by the department after July 1, 1998 will be subject to Chapter 103F, HRS. Chapter 103F does not require the department to monitor purchases of services. However, the interim administrative rules drafted by the State Procurement Office require the department to develop and implement a monitoring plan, including procedures for following up on problems and needed corrective action. However, the interim rules do not specifically require annual site visits to programs providing contracted services. Since on-site visitations are fundamental to program evaluation, the state procurement officer may wish to consider requiring such visits prior to finalizing the administrative rules.

The progress of clients receiving contracted services is not consistently monitored

As noted above, department procedures require that social workers who refer children and families to services offered by private providers request quarterly progress reports on these clients. However, our review of client case files maintained by the private providers indicated that the providers do not always complete the required reports. These reports enable the department to determine compliance with service plans and to determine whether a child can remain in or be returned to a safe family home. When the information is not provided to the department, the effectiveness of contracted services related to client's progress cannot be determined.

Furthermore, in some cases the completed progress reports incorrectly identified the number of days a client participated in services. Inaccurate reports can result in poor decisions with serious consequences. It is imperative that the department ensure that private providers' progress reports are completed, accurate, and reviewed by case workers making key decisions.

The department's inadequate fiscal management of contracted services can result in wasted state funds

Sound contract management ensures that an agency pays only for those services received. To achieve this, the department must be able to identify those clients it refers to each service provider and whether the clients actually participate in the services. Social workers could also use this information to track a client's compliance with a service plan. However, the department does not maintain a master list identifying individuals it has referred to specific private providers. Instead the department obtains this information from the private providers and does not verify the accuracy of the provider's invoices. Moreover, the department's monitoring staff do not consistently review the utilization of contracted services and adjust contract amounts when costs exceed usage.

The department does not ensure the accuracy of private provider invoices

Social workers are required to complete a form authorizing services for individuals they refer to the private providers. Although the department often fails to furnish the private providers with written authorization, the providers will often service the client and bill the State for services. The department can request a refund for any family or individual unit of service for which there was no department authorization so that the department does not pay for clients for whom it has not authorized services. However, in order to implement this management control the department must first maintain a list of all clients authorized to receive services from each provider. This master list should be compared to the private provider's invoices and activity reports before paying for services.

Contract monitors informed us they were provided with a master list of clients authorized to receive services in the past; however, the list was incomplete and resulted in payments being improperly withheld from private providers. In order to prevent unjust delay in provider payments, the monitors allow the private providers to identify those clients authorized to receive services at the department's expense.

The monitors informed us that they review the provider's attendance records to ensure that the clients identified on the provider's list received services. However, this is a futile exercise because it does not provide any assurance that the department authorized services for these clients in the first place. This practice only confirms the consistency of information within the provider's files. Furthermore, the accuracy of the provider's attendance records cannot be confirmed because instead of requiring clients to sign in on the daily attendance logs, the providers at each of the sites we visited completed the logs themselves. Therefore, the department has no assurance that the providers have not inflated their service utilization hours.

Inconsistent utilization reviews result in waste

The compensation and payment schedule included in the department's contracts for fiscal biennium 1997-99 required a review of the utilization of services at the end of FY1997-98. Based on this review, the department was authorized to increase or decrease the contract amounts with each private provider during FY1998-99. This provision ensures that funds can be reallocated to meet changing needs and to prevent unnecessary payments for services not needed.

We reviewed a sample of private provider activity reports for FY1997-98 and found many cases in which the department should have either decreased or increased the contract amount for FY1998-99 to correlate with utilization levels, but did not do so. Had the department made these adjustments, it could have saved at least $180,000.

The department's contract monitors informed us that they complete monthly utilization reviews; however, our review of utilization levels and payments made to private providers indicate that the reviews do not always result in cost savings. For example, one of the contractors paid during FY1997-98 received $127,890 for 2,030 service units that the department did not receive. The contract monitor had identified that the utilization level of this private provider was only half of what the department had contracted for, but no adjustments were made to the contract amount in the subsequent contract year.

Department Needs to Improve Its Title IV-E Determination Process

In our 1990 contracted study of foster care in Hawaii, we criticized the department for substantially underutilizing the potential to claim federal funding for foster care.

The department is eligible to receive federal funds for foster care under Parts B and E of Title IV of the Social Security Act. Title IV-E allows federal reimbursements for foster care maintenance payments (foster care board and care costs), for adoption assistance payments to parents who adopt children with special needs, for child welfare training costs, and for costs related to the administration of the foster care program. If the State is eligible, costs are allowable, and state matching funds are available, there is no limit on the amount of Title IV-E funds that may be claimed.

Under Title IV-E eligibility requirements, the child must have received or must have been eligible for Aid to Families with Dependent Children (AFDC) at the time of removal from the family home and placement in foster care. The child must also be under the age of 18, under the placement responsibility of the department when removed from the home, and live in a licensed foster home. Furthermore, the Family Court must find that remaining in the family home is contrary to the child's best interest and that reasonable efforts were made to prevent placement and to reunify the family. Our earlier study reported that the Family Court had not made reasonable determinations, contributing to the loss of millions in federal funds between 1980 and 1990.

Maximizing federal funds has since been made a department goal. Together the department and the Family Court have made significant progress to increase federal reimbursements, from just over $100,000 during FY1988-89 to over $12 million in FY1997-98. However, further improvements are needed to ensure that federal reimbursements are maximized and that claims are accurate.

Eligibility determinations are untimely

Title IV-E reimbursements may be claimed after eligibility is determined. Therefore, delays in completing an eligibility determination will delay receiving reimbursements. Furthermore, the court determination that removal from the family home is in the best interest of the child must be made within 180 days. Retroactive eligibility claims can be made but are generally limited to about two years after the first foster care payment. Once a deadline has lapsed, federal reimbursements for that case are permanently lost. Since many children remain in foster care for several years, the failure to identify IV-E eligibility in a timely manner can result in the permanent loss of significant funding.

As of June 30, 1998, the department's records indicated that Title IV-E eligibility had not yet been determined for 22 percent, or 461, of the 2,081 children in foster care. We reviewed a sample of the cases in which eligibility had not been determined and identified a number of impediments to eligibility determination that need the department's attention. These obstacles include difficulties in documenting AFDC eligibility, failing to identify all foster care children who have not been screened for eligibility, difficulties in licensing foster homes, and the lack of a judicial determination of reasonable efforts.

There are problems with AFDC linkage

As noted above, a child must have received or have been eligible to receive AFDC benefits at the time of removal from the family home and placement in foster care in order to be eligible for Title IV-E reimbursement. To establish AFDC linkage, the department must identify the parents of the child and whether they meet certain financial deprivation requirements. Even if there is substantial evidence to qualify a child, without documented proof of eligibility AFDC linkage will likely be delayed. This becomes problematic in cases where the paternity of a child has not been established, the parents have abandoned the child, or the parents are uncooperative with the department.

Delays in establishing AFDC linkage were the most common cause of untimely Title IV-E determinations. A federal official informed us that the department should adopt policies to address delays in linkage. In fact, federal officials worked with California's child welfare services staff to develop procedures for addressing inconsistent AFDC linkage procedures. The department should work with federal officials to address linkage delays.

Title IV-E determination cannot be finalized for about 44 percent of the open foster care cases on Maui due to staffing and training deficiencies that have delayed AFDC linkage. Eligibility determination for foster care children is generally completed by income maintenance workers trained in AFDC eligibility requirements. These workers are employed by the Child

Welfare Services Branch or the department's Employment Support Services Division. However, the income maintenance position in the Maui section of the branch was abolished in July 1997, and the Maui income maintenance unit of the division has been unable to meet the Title IV-E eligibility screening demand. Furthermore, Maui's Child Welfare Services Branch does not have staff available who are trained to conduct the AFDC linkage tests. Consequently, a significant number of cases have been pending Title IV-E determination for over a year. Although this problem has been communicated to the administrator of the statewide Child Welfare Services Branch, it has not been addressed.

If the Title IV-E determination rate for Maui were increased to match the rate of the other counties, federal reimbursements could be increased annually by an estimated $81,000. However, if the current condition is allowed to persist, time limits on retroactive claims will prevent federal reimbursements.

Cases are not always referred for Title IV-E eligibility screening

The department requires that social workers complete and forward a form to income maintenance workers indicating a child's placement in foster care within two working days. Designated income maintenance workers are responsible for screening these children for Title IV-E eligibility. However, social workers do not consistently complete the required form or do so in a timely manner. We found several cases that social workers had not referred to income maintenance for determination, including one case in which the social worker presumed that the family's financial status made them ineligible for Title IV-E reimbursement.

When staff fail to comply with the referral policy, there is no assurance that all children placed in foster care are screened for Title IV-E reimbursement. Most staff responsible for screening foster care children for eligibility informed us that they compare the department's monthly report of all children in foster care to their own records in order to identify children who were not referred to them. While we recognize staff's efforts to ensure that all children are screened for eligibility as required by the federal government, we found that this method is not foolproof. While Oahu's income maintenance unit was able to identify a child who had not been referred to it, we were able to identify another foster care child who was not identified by the unit.

In order to ensure eligibility screening for *all* foster care children, the department should consider generating a report that would identify all children who have not been screened for Title IV-E eligibility. The report could also be used to monitor the amount of time a case is pending eligibility determination so that staff can be held accountable for timely determinations.

Obstacles exist for foster home licensing

Foster homes are licensed to ensure that safety standards are met. Federal reimbursement for foster care children is contingent on whether a home is licensed. However, in some cases licensure may be delayed or prohibited by state law.

When a child is placed in an out-of-state foster home, licensing certification of the home by the department may be delayed because an interstate compact between states requires that the state placing the child license the foster home in accordance with the rules of the state of residence. Delays in licensing an out-of-state foster home have also delayed Title IV-E eligibility determination. Moreover, once an out-of-state license is received by the social workers, this information is not always communicated to staff who screen for Title IV-E eligibility.

Chapter 346, HRS, establishes licensing requirements for foster homes. Currently, the law restricts licensure to homes with fewer than six minor children. This has resulted in the loss of potential Title IV-E reimbursements when children are placed in foster homes with more than five children. We reviewed a case in which the court ordered that eight siblings be placed together in their grandparents' home. Although the children met all other eligibility requirements, Title IV-E reimbursements could not be claimed for the $92,000 in foster care paid by the State because the home was unlicensed due to the number of siblings housed together.

Allowing foster homes to be licensed in exceptional circumstances when it is in the best interest of the children would allow the State to claim federal funds currently being lost due to state licensing requirements. The department plans to propose changes to Chapter 346, HRS, to address this issue.

Judicial determination of reasonable efforts is absent

Eligibility for Title IV-E reimbursements also requires a judicial finding within 180 days of the child's removal from the home that remaining in the family home is contrary to the child's best interest. However, the department has allowed children to remain in voluntary foster custody beyond 180 days. Consequently, the department cannot claim Title IV-E reimbursements for otherwise eligible children. Our 1990 study on foster care reported the State's loss of hundreds of thousands of dollars in federal reimbursements as a result of extended voluntary placements. The loss of federal funds coupled with the liability risks for children illegally placed in voluntary foster care as discussed earlier demand that the department develop controls to sufficiently monitor voluntary foster custody placements.

Federal reimbursement claims are inaccurate

The federal government reimburses a portion of Title IV-E funds for related administrative costs based on the percentage of Title IV-E eligible foster care children. The percentage of children who are identified as Title IV-E eligible is referred to as the State's penetration rate. A higher penetration rate results in higher federal reimbursement.

When calculating the State's penetration rate, the department identifies the number of children eligible and ineligible for Title IV-E as indicated in the CPSS. However, we identified a significant number of undetected coding errors in CPSS, challenging the accuracy of the department's reimbursement claims. Some of the errors we identified caused some claims to be understated or not stated at all. More frequently, though, the errors had the effect of understating the total population count used to compute the State's penetration rate, thus overstating claims for administrative reimbursements.

Department Needs to Improve Its Fiscal Management to Reduce Overpayment Losses

Foster care board and maintenance payments, including adoption assistance and independent living assistance, comprise about 35 percent of the department's child welfare services budget. To ensure the efficient use and maximization of these funds, management controls are needed to minimize the risk of improper payments.

Specifically, the department needs to improve its management controls to prevent overpayments for foster care and temporary assistance. It should also improve the management of its overpayment and expenditure reports to ensure that losses are properly identified and pursued in a timely manner.

Overpayments to foster care providers can be reduced

Foster care payments to a foster parent or provider should be made only for the time a child actually resides in the foster home. Children may be moved to several foster homes for various reasons, and the department should accurately track the information in order to ensure appropriate payments for each foster parent or provider. The department has established a management control within CPSS that permits only one payment to be issued for each child in foster care. However, the controls in place to ensure that all payments to a foster parent stop once a child leaves foster care are inadequate.

Child welfare services staff are responsible for updating the CPSS with changes in foster placement information. However, changes are not always made when a child leaves foster care. In two cases we reviewed, because the social workers failed to make contact with the children, they were unaware that the children were no longer residing in the foster home or agency to which foster care payments were made. In

one of these cases, an agency was paid $8,583 in overpayments over a 16-month period. In the second case, the department paid a foster family $3,685 over a six-month period after the child had left the home. While these overpayments were identified in the CPSS overpayments and claims reports, the amounts had not been recovered at the time of our fieldwork.

Overpayment management report is deficient

The CPSS generates a monthly report detailing outstanding foster care overpayments and claims. The report indicates that overpayments for the quarter ending June 1998 amounted to about $25,000. Overpayments of this magnitude should not be ignored.

The report, however, contains substantial errors, limiting its usefulness. In one case, the report incorrectly indicated that the department overpaid $7,167 for three siblings' foster care over four months. Actually, the foster parent was overpaid only $52.

We reviewed the overpayment report and found some transactions dating back to 1995. Many of the overpayments were for minor amounts. If collection is unlikely or pursuing collection exceeds the amount due, the department should consult with the attorney general for the purpose of writing off such accounts. Section 40-82, HRS, authorizes departments, with the approval of the attorney general, to delete uncollectible accounts that have been delinquent for two consecutive years from its accounts receivable.

However, child welfare services staff and supervisors informed us that they do not know who is responsible for maintaining the records on overpayments. Furthermore, they complained that the report continues to show items as overpayments even when the overpayments are resolved or recovered. The department should assign responsibility for ensuring the reliability of the overpayment report to maximize its usefulness as a tool for management control.

Excess benefits paid to families receiving temporary assistance are not consistently recovered

The department's controls are also ineffective to ensure that Temporary Assistance to Needy Families (TANF) is adjusted when a child is placed in foster care. However, the income maintenance workers responsible for issuing TANF payments do not always receive the necessary information to adjust temporary assistance payments in a timely manner. Furthermore, even when the information is received, income maintenance workers do not routinely adjust assistance payments and flag overpayments. This makes recovery of overpayments unlikely.

Adjustments are not made

TANF is paid in advance for a full month. However, this rule does not apply when a child is placed in foster care. Department policy and federal regulations require that partial-month benefits be classified as overpayments and be recovered when a child is removed from the home receiving TANF and placed in foster care paid for by the State.

We reviewed a statewide sample of 46 families receiving temporary assistance payments from the department and found that 15 families continued to receive benefits for their child(ren) in the month following the child(ren)'s placement in foster care. Yet because the department is able to stop an overpayment within three days of the month's end, the State had sufficient time to adjust the benefits and stop the avoidable overpayments in most of these cases. Consequently, the State paid double benefits to 11 families in our sample, amounting to about $7,000.

Overpayments are not flagged

Overpayment during the month of the child(ren)'s removal could not be avoided in 31 of the cases in our sample because the child was removed from the family home after TANF payment had been received. When the overpayment cannot be avoided, the department requires that the income maintenance worker flag it as such in the Hawaii Automated Welfare Information (HAWI) system, which tracks financial assistance. This is to ensure that the department's recovery system will include the overpayment in its automated recovery efforts. None of the overpayments we identified were flagged as required; therefore, the department did not initiate recovery efforts, which may include requests for reimbursements and the adjustment of tax refunds.

Furthermore, four of these families received assistance benefits in subsequent months that were neither flagged nor recovered. This violates department and federal policies that require recovery of these overpayments.

Financial management for adoption assistance and independent living assistance can be improved

The department was unable to provide us with separate reports for all adoption assistance and independent living assistance payments made during the quarter ending June 1998. Instead, these payments were included in the department's foster care payment report. We selected a statistical sample from this report to review the accuracy of foster care, adoption assistance, and independent living assistance payments.

Our randomly selected sample did not include any payments for independent living assistance; therefore, we are unable to comment on the accuracy of these payments. Our review did include payments for adoption assistance. We found no errors. However, the department

failed to justify whether families receiving adoption assistance beyond one year continued to meet the criteria required for assistance. Department policy requires an annual review to determine whether assistance is still needed; however, in our sample we found no review was conducted for any of the cases that required such a review. In one case, we found no evidence that a review had been conducted since 1990. Staff should routinely conduct the annual review as required in order to ensure that these funds are limited to families qualifying for assistance.

Furthermore, we concluded that the department could improve its management of independent living assistance payments by printing quarterly expenditure reports for this program apart from the foster care payment report in order to identify and monitor program costs. This practice would allow the department to quickly identify any questionable increase or decrease in these programs. The failure to monitor independent living costs separately from foster care costs could result in gross overpayments or fraud remaining undetected. Subsequent to our fieldwork, the department was able to provide us with monthly expenditure reports for adoption assistance payments.

Conclusion

Child safety, the genesis for needed change in the current child protective services system, demands that improvements be made in communication, decision-making, and service delivery. Key to each of these areas is the need to maintain a reliable central registry of child abuse and neglect reports, and to establish controls to track the provision of services to families and children. Instead, incomplete and inaccurate data has hindered the department's ability to make key decisions, monitor services, and track overpayments.

Recommendations

1. The Department of Human Services should establish sufficient management controls to ensure that all child abuse and neglect reports are investigated as appropriate. Specifically, the department should:

   a. Accept for intake all reports of suspected abuse and neglect. Reporters should be informed of either the department's decision not to investigate the report or the investigative disposition;

   b. Require that all reports of suspected abuse and neglect received by the department are recorded on intake logs and in the department's central registry for abuse and neglect (CPSS);

   c. Ensure that supervisors review and document in a timely manner all cases not referred for investigation and all cases of

unconfirmed or unsubstantiated abuse. Should the department decide to facilitate such review through CPSS, it should implement adequate security controls to ensure that supervisory review cannot be bypassed through unauthorized access by staff;

d. Track all cases referred to investigation and ensure that dispositions are made within 60 days. Investigators who fail to comply with this policy should be held accountable; and

e. Provide training and oversight to ensure that the risk assessment matrix is properly used during case intake, assessment, and management. Social workers should be held accountable when the matrix is not used as required.

2. Communication between the Child Welfare Services Branch, the county police, and the Family Court should be improved. Improvements should:

   a. Ensure that background screens are routinely completed by child welfare services staff for all new reports of suspected abuse and neglect;

   b. Standardize written agreements between the department and each county police department to ensure that reports of serious abuse and neglect are routinely shared. At a minimum, the department should comply with the Hawaii Administrative Rules' requirement that it refer all cases involving criminal activity, including sexual abuse, to the county police. The Legislature should consider amending Chapter 350, HRS, to specify the circumstances in which the department must inform the police of reported abuse and neglect;

   c. Require the county police to immediately comply with the provisions of Chapter 350, HRS, which mandates reporters to inform the department of all cases in which abuse or neglect is suspected; and

   d. Require the department to more carefully monitor voluntary foster custody placements and service plan compliance to ensure that family court jurisdiction is sought when required. Furthermore, the department should immediately review all current voluntary foster care placements and ensure that the department has legal authority for each child voluntarily placed in foster care.

3. As appropriate, the Family Court should more frequently hold parents unwilling to comply with court ordered service plans in criminal contempt of court as authorized under Section 587-77, HRS. The

court should also make determinations that these parents are not presently or in the reasonable foreseeable future willing or able to provide the child(ren) with a safe family home. The department and Family Court should move for permanency hearings when families are unwilling or unable to complete court-ordered services that are available and appropriate.

4. The Legislature should amend Chapter 587, HRS, to clarify that permanency planning *must* begin within 12 months after a child's placement in foster care. This will ensure compliance with the federal Adoption and Safe Families Act of 1997.

5. The department should improve its management of contracted services. Specifically, the department should:

   a. Conduct annual on-site visits to each program funded by purchase of service agreement and provide contractors with timely feedback for those areas requiring corrective action;

   b. Identify in a monthly master list all children and families it has authorized to receive services from each private provider. Contract monitors should compare this list to the contractors' invoices and activity reports prior to authorizing payments;

   c. Track all children and families receiving services and require that quarterly progress reports be submitted by the service provider and reviewed by the case worker; and

   d. Consistently review utilization levels for each private provider after the first contract year and make adjustments in contract levels for the upcoming contract year to ensure that costs do not exceed usage.

6. The department should improve its ability to capture all available Title IV-E funds and to accurately claim administrative reimbursements. Specifically, the department should:

   a. Work with federal officials to develop procedures to minimize delays in AFDC linkage when parents either cannot be found or are uncooperative;

   b. Formally designate and train staff who are to be responsible for all components of Title IV-E determination on each neighbor island;

   c. Track all children placed in foster care to ensure that they are referred for Title IV-E eligibility determination within two days; and

d. Properly identify in CPSS each child placed in foster care as either eligible or ineligible for Title IV-E reimbursement.

7. The department should hold staff accountable for preventing overpayments for foster care and temporary assistance to families whose children are placed in foster care. The department should also ensure recovery efforts for outstanding overpayments. Specifically, the department should:

   a. Require social workers to update the CPSS with foster care placement information and to contact foster children to ensure that payments do not continue to families once a child has left a foster home without the department's knowledge;

   b. Require that child welfare services staff notify income maintenance workers of a child's removal from the family home when the family is receiving Temporary Assistance to Needy Families. Income maintenance workers should be held accountable for adjusting the benefit payment and recovering overpayments when notification of a child's removal is too late to prevent the overpayment from occurring; and

   c. Require income maintenance workers to flag all overpayments for temporary assistance in HAWI to ensure that these overpayments will be included in the department's recovery efforts.

8. The department should appoint a child welfare services staff person to be responsible for ensuring the accuracy of child welfare services' overpayment reports, recovering overpayments in a timely manner, and requesting that the attorney general write off payments that cannot be recovered as allowed in Section 40-82, HRS.

9. The department should improve its management of adoption assistance by ensuring that staff annually review eligibility for this program. The department should also improve its management of independent living assistance payments by identifying monthly expenditures for these programs separately from foster care.

Responses of the Affected Agencies

Comments on Agency Responses

We transmitted drafts of this report to the Department of Human Services, the Judiciary, the Department of the Attorney General, and the Honolulu, Hawaii, Maui, and Kauai county police departments on January 7, 1999. A copy of the transmittal letter to the Department of Human Services is included as Attachment 1. Similar letters were sent to the Judiciary, the Department of the Attorney General, and the Honolulu, Hawaii, Maui, and Kauai county police departments. The responses from the Department of Human Services, Judiciary, and Honolulu and Hawaii police departments are included as Attachments 2 through 5 respectively. The Department of the Attorney General and the Maui and Kauai police departments did not submit responses.

The Department of Human Services responded that as a whole, it concurs with our findings and recommendations and feels confident that it will be able to effectively implement necessary corrective action. The department also suggested some clarifications, most of which did not require any changes to our draft report.

In its clarifications, the department expressed its belief that the Title IV-E penetration rate will be negatively affected if a determination of eligibility or ineligibility is made for all children in foster care who are currently pending eligibility determination. However, while the federal government allows the department to "pend" children, we do not believe that it intends that states maintain children in pending status indefinitely in an attempt to maximize federal Title IV-E reimbursement claims. Furthermore, as noted in our report, the department's inaccurate coding of the eligibility status of foster care children in the automated Child Protective Services System (CPSS) has resulted in inaccurate federal reimbursement claims.

The Judiciary commented that it plans to disseminate to all Family Court judges—and place on an agenda for discussion at the next meeting of these judges—our Recommendation No. 3 which suggests that the Family Court should (1) as appropriate, more frequently hold parents unwilling to comply with court-ordered service plans in criminal contempt of court, (2) make determinations that these parents are not willing or able to provide the child(ren) with a safe family home, and (3) with the Department of Human Services, move for permanency hearings when families are unwilling or unable to complete court-ordered services that are available and appropriate.

The Judiciary recommended a broader version of our draft Recommendation No. 4 concerning the consistency of Hawaii law with

the federal Adoption and Safe Families Act of 1997. We encourage further discussion of the Judiciary's suggestion; however, our recommendation is limited to the issue addressed in our draft report.

The Honolulu and Hawaii police departments responded to certain concerns raised in our draft report by describing some of their activities in child protection.

We made some editorial changes in our draft report for the purposes of clarity and style.

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

January 7, 1999

COPY

The Honorable Susan M. Chandler
Director
Department of Human Services
Queen Liliuokalani Building
1390 Miller Street
Honolulu, Hawaii 96813

Dear Dr. Chandler:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Audit of the Child Protective Services System.* We ask that you telephone us by Monday, January 11, 1999, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Friday, January 15, 1999.

The Judiciary, Department of the Attorney General, the police chiefs of the City and County of Honolulu, County of Hawaii, County of Maui, and County of Kauai, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

ATTACHMENT 2

BENJAMIN J. CAYETANO
GOVERNOR

SUSAN M. CHANDLER, M.S.W., Ph.D.
DIRECTOR

KATHLEEN G. STANLEY
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

P.O. Box 339
Honolulu, HI 96809-033

January 15, 1999

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STATE OF HAWAII

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, HI 96813-2917

Dear Ms. Higa:

Thank you for the opportunity to review and comment on your draft report, Audit of the Child Protective Services System. We appreciate the time and effort your analysts took to understand the intricacies of the Child Welfare Services programs and operations.

As a whole, we concur with the report's findings and recommendations. We acknowledge the need to implement more consistently some of our current practices such as supervisory review of cases, recording of intake reports, use of the risk assessment matrix, and annual monitoring of contracts. We are also attempting to move in directions which will lead to formal agreements with the county police departments and closer monitoring and evaluation of services provided to our clients by contracted private agencies.

We would like to suggest a small number of clarifications which are described in an attachment to this letter.

In response to your report, we feel confident that we will be able to effectively implement necessary corrective action.

Sincerely,

Susan M. Chandler

Susan M. Chandler
Director

Attach.

AN EQUAL OPPORTUNTY AGENCY

ATTACHMENT

Items of Clarification:

1. Page 28 (paragraph 1) and Page 31(paragraphs 1 & 2)

It is agreed that every effort must be made to determine as accurately and completely as possible the Title IV-E eligibility of our foster care population. However, with concurrence of Federal officials, we classify as "pending" all children known to be in foster care who have not been determined to be either eligible or ineligible for IV-E and to disregard these pending foster children as part of the IV-E base population. As a result, we have been able to maximize our penetration rate by minimizing the denominator. This is advantageous because children for whom we cannot obtain sufficient information to make a determination are more likely to eventually be found ineligible.

2. Page 30 (paragraph 2)

IV-E eligibility screening is not impeded by delays in the licensing of foster homes. Eligibility staff do not have to await this information in order to determine eligibility. However, a delay in licensing would delay the payment and claim. When licensing approval is entered into the License Resource File (LRF) the claim for the eligible child is triggered.

3. Page 30 (paragraph 5)

Regarding the 1990 study, DHS had no provision in its rules to allow IV-E eligibility for voluntary placements until November 1992. Though it may be a factor today, extended voluntary placement would not have been a specific factor in the loss of IV-E reimbursements in 1990.

4. Page 36 (Recommendation 6, part d)

Identifying all children in placement only as either eligible or ineligible would negatively affect the IV-E penetration rate. Identifying as "pending" children for whom we do not yet have sufficient eligibility information allows us to exclude them from the base population (denominator) from which the penetration rate is calculated.

5. Page 37 (Recommendation 9)

Although it is in our rule that we "re-certify" adoption assistance (AA) cases for eligibility annually, Federal officials have indicated that AA eligibility should not be redetermined. Therefore, the new (proposed) rule calls for biennial "review."

6. Page 37 (Recommendation 9)

Ongoing assistance payments are not made as part of the Independent Living program. Assistance payments to foster youth attending institutions of higher learning are made under the title, "Board - higher education," and are tracked separately from other foster board payments.

Office of the Administrative Director of the Courts THE JUDICIARY • STATE OF HAWAI'I
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Michael F. Broderick
ADMINISTRATIVE DIRECTOR
Clyde W. Namu'o
DEPUTY ADMINISTRATIVE DIRECTOR

January 15, 1999

Ms. Marion M. Higa
State Auditor
Office of the State Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813

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OFC. OF THE AUDITOR
STATE OF HAWAII

Dear Ms. Higa:

Thank you for the opportunity to comment on the draft report, *Audit of the Child Protective Services System.*

The Judiciary agrees with your assessment "[t]hat balancing child protection, parental rights and the family unity is an arduous task...". That balancing becomes more difficult considering the tragedy that occurs when a child is not removed from, or is returned to, an unsafe home, realizing that most children have an intense desire to be in their own home. Balancing also the possible harm children sometimes suffer in foster care, guardianship or adoptive placements, and the task becomes even more daunting. These cases deserve the highest priority from all who work in the child welfare system.

Recommendation number 3 states as follows: "As appropriate, the Family Court should frequently hold parents unwilling to comply with court ordered service plans in criminal contempt of court as authorized under Section 587-81, HRS. The court should also make determinations that these parents are not presently or in the reasonable foreseeable future willing or able to provide the child(ren) with a safe family home. The department and Family Court should move for permanency hearings when families are unwilling or unable to complete court ordered services that are available and appropriate.", I want to assure you that this recommendation will be disseminated to all family court judges, and it will be placed on an agenda for discussion at the next meeting of the family court judges. For clarification, I believe the reference to HRS § 587-81 is intended to be a reference to HRS § 587-77.

The terms "permanency plan" in the Adoption and Safe Families Act of 1997 (ASFA), and "permanent plan" in HRS § 587 have been the source of some confusion. The federal statute requires a clear statement of the goal, family reunification or permanent placement out of the home, within 12 months from the time that the child is placed in foster custody. ASFA also requires the filing of a termination of parental rights petition if the child has been in foster custody for 15 out of the last 22 months. For these reasons, the Judiciary suggests that recommendation number 4 be changed to recommend that the Legislature amend Chapter 587 to insure that Hawai'i Law is in complete compliance with ASFA with respect to permanency plans and termination of parental rights.

Thank you again for providing the Judiciary the opportunity to review your draft.

Yours very truly,

Michael F. Broderick
Administrative Director of the Courts

POLICE DEPARTMENT

CITY AND COUNTY OF HONOLULU

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JEREMY HARRIS
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LEE D. DONOHUE
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WILLIAM B. CLARK
MICHAEL CARVALHO
DEPUTY CHIEFS

OUR REFERENCE GM-NTK

January 15, 1999

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STATE OF HAWAII

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

We have reviewed the draft report of the "Audit of the Child Protective Services System." It appears the main issue of concern regarding the Honolulu Police Department (HPD) is the failure to report all abuse and neglect cases to the Department of Human Services (DHS).

HPD has entered into a written agreement with DHS requiring the cross reporting of abuse and neglect cases. HPD is making every effort to address this matter.

A Child Abuse Detail has been established, agreements have been entered into with DHS, and notices have been issued to departmental personnel requiring the immediate notification to DHS on these types of cases. In addition, there are monthly interagency meetings to address ongoing concerns.

Sincerely,

Lee D. Donohue

LEE D. DONOHUE
Chief of Police

Stephen K. Yamashiro
Mayor

Wayne G. Carvalho
Police Chief

James S. Correa
Deputy Police Chief

County of Hawaii

POLICE DEPARTMENT

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January 15, 1999

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STATE OF HAWAII

Ms. Marion M. Higa
State Auditor
State of Hawaii
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

Thank you for allowing us to comment on the draft report "Audit of the Child Protective Services System."

Regarding paragraph 4 on page 19 of Chapter 2, we would like to clarify that our Department has procedures in place that fulfill the mandates of Chapter 350 of the Hawaii Revised Statutes, and we conduct our investigations as required within the purview of the statute.

We also have adopted a protocol with the Child Protective Services, Office of the Prosecuting Attorney, and Children's Advocacy Center which defines our role in child sexual abuse cases.

Additionally, a proposed draft of an interagency protocol for child physical abuse is currently being reviewed by the above-named agencies.

If you have any questions, please contact Lieutenant Ronald Nakamichi of our Juvenile Aid Section at (808)961-2254.

We appreciate being provided with the opportunity to clarify our role in these important matters.

Sincerely,

WAYNE G. CARVALHO
POLICE CHIEF

JAMES S. CORREA
DEPUTY POLICE CHIEF
ACTING POLICE CHIEF
RN:if/lk