



THE SOUTH CAROLINA SENATE

DSS OVERSIGHT

SUBCOMMITTEE

The South Carolina Senate DSS Oversight Subcommittee Report and Recommendations

March 2015

The Department of Social Services Oversight Subcommittee is a subdivision of the Senate General Committee appointed by Committee Chairman Senator William O'Dell in November 2013. Chairman O'Dell appointed three members to serve on this subcommittee: Senator Katrina Shealy of Lexington, Senator Joel Lourie of Richland, and Senator Tom Young of Aiken as its Chairman. From January 2014 through December 2014, the subcommittee met 13 times to hear testimony from experts, community advocates, parents, concerned citizens, and government officials. Throughout these meetings, the subcommittee received numerous suggestions, recommendations, and ideas to improve the child welfare system in South Carolina.

In October 2014, the South Carolina Legislative Audit Council (LAC) released its most recent audit of Child Protective Services at DSS. Many of the subjects covered herein will overlap with the LAC's recommendations from their October 2014 report. This is consistent with the shared aim and purpose that the subcommittee and the LAC had when working on examining South Carolina's child welfare system. The LAC reported their findings to the DSS Oversight Subcommittee at the October 2014 meeting and the Subcommittee's members support the findings and recommendations contained therein.

In this report, the Subcommittee selected several areas of focus for both legislative and Agency policy changes in areas affecting child welfare. The Subcommittee views its work as a major first step in bringing about needed reforms. Policymakers, the Governor, and DSS staff must work together to implement initiatives to sharpen investigations, support quality casework, improve services and child outcomes, strengthen families, build community partnerships, and prevent child maltreatment. By implementing many of the suggestions contained herein, necessary changes will occur and South Carolina will be a better and safer place for children and families.

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District 23

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1. Child Fatalities And Severe Injuries

The most disturbing testimony received by the Subcommittee involved the State's child fatality rate and the rate of severe injuries among children with some contact with DSS. Regretfully, the Subcommittee recognizes that, even under the best circumstances, some children in DSS' care may die or sustain severe injuries. DSS' responsibilities include to implement policies and to equip its employees with the resources to reduce the number of child fatalities and severe injuries as much as possible. DSS is not alone in protecting child welfare; law enforcement and other state agencies also play a vital role. Nevertheless, DSS must take primary responsibility for the State's shortcomings in this area and must improve its policies, procedures, and employee training to better provide protective services for our State's most vulnerable children.

Additionally, the Subcommittee is not satisfied with the child fatality data available for public review. The statistics reported to the Subcommittee varied based upon its source. The most reliable data appeared to come from the Child Fatality Unit of the State Law Enforcement Division. The State must collect accurate data related to child fatalities and severe injuries so that the public, the Agency, and policy makers may better understand the root causes and address them.

RECOMMENDATIONS:

Agency Action

- Develop a clear, easily understood standard for collecting and reporting accurate child fatality data. The standard must not be an attempt to minimize DSS' culpability or shift the blame to law enforcement and other agencies. SLED noted that there are inconsistencies in data provided by coroners from county to county. DSS should engage SLED to assist with developing the standard as it relates to the work of the Child Fatalities Unit;
- Continue to improve coordination with law enforcement as to child protective matters; particularly when DSS knows that a child is at an increased risk of severe injury or death;
- Work with the Department of Health and Environmental Control, the State Law Enforcement Division, the Department of Public Safety, and the SLED Child Fatality Advisory Committee to improve data sharing to improve reports;

- Work with the relevant stakeholders to establish protocols for reporting complete, accurate child fatality data including the cause of death, state or local involvement with the child, action taken by a state agency on behalf of the deceased child’s welfare, and other relevant information;
- Create child fatality data website similar to the website for Florida.

Legislative Action

- Allocate additional funding and authorize additional FTEs to the Child Fatality Unit of the State Law Enforcement Division so that SLED may improve upon and expand the number, quality, and speed of child fatality investigations;
- Require the Department of Public Safety and the Department of Transportation to report child fatality data to DSS and to the State Child Fatality Advisory Committee for review and inclusion in overall child fatality statistics. Enact legislation penalizing county coroners who fail to report child fatalities pursuant to SC Code Sec. 17-5-540;
- Create Local Fatality Review Teams to review child fatalities as a result of abuse and neglect. These would include county coroner, pediatrician(s), and others within a county or region. Recommended in testimony and implements a 2003 recommendation from the State Child Advisory Committee.

2. Intake and Investigations

The first contact that a child has with DSS often results from an allegation of child abuse or neglect. Upon receipt of the allegation, DSS begins its “intake” process which includes screening the allegation so that an appropriate response may be initiated. This intake must be done timely, efficiently, and accurately. Testimony showed that the intake process and screening varies from county to county and that responses to allegations routinely fall short of statutorily mandated timelines. This is unacceptable. DSS must improve and standardize this process.

Other testimony showed that DSS initiates investigations too slowly in far too many instances. This too is unacceptable especially considering that the 1985 Legislative Audit Council Report noted that DSS did not timely investigate abuse and neglect allegations. Simply put, testimony suggests that DSS has not consistently gathered, assessed or used appropriate information to make accurate and timely decisions.

RECOMMENDATIONS:

Agency Action

- Implement and maintain a centralized statewide or regional intake process to receive all reports of abuse or neglect that must be operational for 24 hours, 7 days a week. This intake plan should include a 24 hour/7 day a week statewide telephone hotline and a secured web site for reporting suspected abuse or neglect;
- Implement measures to reduce response time and investigation timeframes: If an allegation warrants an investigation, or a referral to a community based program, face-to-face contact with the child should be made as soon as possible within 24 hours. Where the child is a disabled child; is under the age of 2; or is in a particular risk for harm, the child should be located immediately. Require law enforcement notification if face-to-face contact is required but the child cannot be located. Maintain current standard that DSS initiate an investigation within 24 hours;
- Use an evidence-based intake assessment tool to determine whether a report of abuse or neglect shall be forwarded for an investigation, referred, or no action. Routinely review and reassess the tool for effectiveness, then revise as necessary. Photograph all children whose abuse or neglect is the subject of an investigation and maintain those photos on file for caseworker verification purposes;
- Allocate resources to focus on maintaining a qualified, properly trained investigations unit that can identify signs of abuse or neglect and properly respond where signs of abuse and neglect are present;
- Ensure that intake is consistent and uniform independent of the relationship of the alleged perpetrator to the child.

Legislative Action

- Provide proper funding and resources to DSS to maintain the investigations unit as recommended above;
- Enact legislation requiring DSS to respond to reports within specified time periods depending on the level of severity - current state law (Section 63-7-920(A)(1))requires DSS to begin an investigation of a report of suspected child abuse within 24 hours of

receiving the report – best practices suggest that a shorter time period should be required depending on the age, health or possible disability of a child and the severity of the allegations in the report;

- Require DSS to use an evidence-based intake assessment tool to determine whether a report of abuse or neglect shall be forwarded for an investigation, referred, or no action. Require the tool be routinely reviewed and reassessed for effectiveness, then revised as necessary;
- Grant DSS access to FBI data (NCIC database check) for caregivers in the home of child that is subject of abuse or neglect investigation and where a child will be placed;
- Require law enforcement to report when an arrest is made for domestic violence and a child is present and allow DSS to assess the report like all other reports of abuse or neglect;
- Remove state-level barriers to sharing data across agencies and focus on risk-based policies.

3. Caseworker Retention and Caseloads

Some of the most high profile testimony related to caseworker retention and caseloads. Notably, the 1985 Legislative Audit Council Report found that caseworker caseloads varied excessively from county to county. Unfortunately, the Subcommittee spent months trying to ascertain the accurate caseworker caseload data in part because the data provided by the agency did not reflect the excessive number of cases carried by many caseworkers in various counties. However, after the agency provided more reliable data and heard the Subcommittee’s significant concerns expressed as to this area, the agency implemented mid-year reforms which are encouraging going forward.

The Subcommittee also notes significant areas of concern related to recruiting and retention of employees and training and certification of employees. DSS must do more to hire and retain qualified caseworkers.

RECOMMENDATIONS:

Agency Action

- Develop and implement a program focused on employee recruitment for child protective services taking into account undergraduate degrees or relevant work experience in related fields, a competitive pay scale, and opportunities for advancement;
- Refine new caseworker employee training so that new caseworkers are more quickly deployed to the “field” while still maintaining the level of quality necessary to prepare them for their work;
- Focus on establishing a “career path” for those employees and potential employees interested in casework. Also, consider allowing for more flexible management of caseworkers. Kentucky has implemented a management system that replaced strict classifications of employees and related tasks with more a more generic organization where employees have a wide array of tasks and responsibilities. The decision-making as to which employees handle which types and how many cases is made on a local or regional level based upon the personnel in each location. The reforms in Kentucky have had a positive effect on retention rates. Other states including Georgia have implemented programs in their child protection agencies to develop professional staff and improve the quality of work and the rate of retention of workers;
- Ensure that agency accountability measures do not increase paperwork for case workers such that their time is not spent with working with assigned children.

Legislative Action

- Require DSS either through statute or regulation to adopt new standard that measures caseload by children -- not families and be able to amend and adjust that limit to reflect evolving standards;
- Codify requirements of social work or behavioral health degree, with substitutions for experience for all caseworkers. Extend qualifications to foster care and adoption workers.

4. Licensing of Child Care Facilities

Testimony showed that South Carolina has minimal licensing and registration requirements for child care facilities. With little regulation, some children have died in facilities that appeared to meet the minimum state qualifications. In a comparison of the 50 states in this area, South Carolina recently was ranked 41st in the nation with a notation that

no state agency inspects family child care homes prior to the state's issuing a license.¹ Currently in South Carolina, licensing is not required until a provider is caring for seven children in the home. Many states require registration or licensing regardless of the number of children in the home's care. Moreover, an inspection must be undertaken in order to obtain that license. Both Oklahoma and Georgia have recently enacted changes and are now ranked amongst the top states in the nation in this area.

RECOMMENDATIONS:

Agency Action

- Report its findings after every investigation;
- Post inspection data online;
- Require child care facilities to maintain minimum limits of liability insurance coverage for each occurrence of negligence;
- Establish that violations of DSS guidelines must result in a monetary fine and egregious violations must result in license revocation for period of time;
- Establish that a third violation by any facility within a two year period must result in license revocation for period of time;
- Require all day care facilities to report the identity and contact information for each of the children in their care to DSS on a monthly basis with the information to include the child's name; the parent's name(s) and address(es); and parent's contact phone numbers.

Legislative Action

- Direct DSS to investigate all complaints of registered and licensed child care facilities and create greater flexibility to monitor. With a single founded complaint, require a registered provider (6 or fewer children) to apply for licensure or cease from providing services;
- Enact legislation similar to the changes implemented recently in Oklahoma and Georgia;
- Require all day care facilities to be licensed -- not merely registered -- if they provide non-family care;

¹ NACCRA 2012 Ranking of States for Program and Oversight Benchmarks Combined, http://www.naccra.org/sites/default/files/default_site_pages/2012/lcc_ranking_total_scores_0.pdf.

- Examine and determine under what circumstances day care facilities should be inspected without prior notice by DSS personnel and fire and law enforcement personnel;
- Examine and determine application and extent of minimum health and safety standards either by statute or regulation;
- Require ratings of all day care facilities be made available to the public online.

5. Community Based Prevention Services (CBPS)

Community Based Prevention Services are privately managed programs under contract with DSS that provide services to families designed to assist the parents, or a person acting as a parent, alleged to have abused or neglected a child to better address their own needs and the needs of the child. DSS refers cases to CBPS when a caseworker determines that an allegation of abuse and neglect does not arise to a level of risk of “substantial harm.” Evidence suggests that the CBPS program has resulted in fewer children being investigated by DSS because caseworkers are simply referring them to a CBPS provider to manage caseloads. Further, there has been an increase in abuse and neglect suffered by children whose cases were referred to CBPS programs. This testimony is very troubling. The Subcommittee agrees with the LAC recommendation that CBPS be continued but managed more closely by DSS.

RECOMMENDATIONS:

Agency Action

- Employ in-house case managers to coordinate the services provided to families and children through CBPS to ensure accountability and consistency of services;
- Initiate a policy that when a family referred to CBPS declines to participate, or fails to participate, DSS reevaluates the case to ensure that the well-being of the child does not warrant further action by DSS;
- Establish a transparent evaluation of program effectiveness for all CBPS. A provider found to be lacking based upon DSS evaluation should be disqualified from contracting with DSS for some period of time, at least one year, after being found disqualified. In addition to the one year prohibition on contracting, a provider who has been found disqualified must demonstrate to DSS that the factors disqualifying the provider previously have been satisfactorily addressed;

- Do not allow CPBS to investigate allegations of abuse and neglect – that should be done by DSS staff.

Legislative Action

- Establish an independent board to supervise, review, and issue licenses to CBPS program participants. The legislation should establish criteria that an applicant must possess to be licensed and for a licensee to maintain its license.

6. Foster Care, Alternative Care and Group Homes

Foster care and group homes are an important aspect of child welfare. They are designed to provide children a safe environment in which to learn and to grow. In many instances, foster care, alternative care and group homes have positively impacted children. However, on some occasions, they have been detrimental to children. That is why DSS must closely manage children in foster care, alternative care, and group homes. Faith based homes have a significant role to play for many children across the state and DSS should embrace the faith based community in assisting children in need within the child protective services system.

RECOMMENDATIONS:

Agency Action

- Require foster care parents to undergo quality training and retraining in order to provide them with the skills necessary to provide a safe and stable home for children under their care;
- Establish uniform statewide foster care standards;
- Provide ongoing training for caseworkers and adjust caseloads so that caseworkers can more effectively manager foster care cases. Caseworkers should periodically review each case to confirm that children in their care have been provided with all services available to them;
- Caseworkers should more closely manage alternative care providers, typically family members, entrusted with caring for children. The caseworker should confirm that services available to the children have been provided and that the alternative care provider is providing a safe and stable home;

- Initiate a system where caseworkers can share or transfer cases when a child is assigned to a foster home more than one county away from the child's home;
- Require that a child's age and any special needs be a significant factor when assigning the child to a group home;
- Develop and implement a quality statewide campaign to recruit foster families. Utilization of current resources through established organizations is highly encouraged.
- Evaluate the competitiveness of foster care subsidies compared to other states, accounting for the cost of living, and whether current subsidy rates provide appropriate assistance to families and children;
- Implement surprise inspections of foster homes, group homes and kinship care homes as a possible effective tool in ensuring consistent quality and adherence to standards of care for a child;
- Consider regionalization of licensing for foster care homes.

Legislative Action

- Provide local foster care review boards with a more definite role in the family court process;
- Require periodic 3rd party performance audits of the foster care program;
- Provide that grandparents are afforded a preference when making placement decisions related to foster care or alternative care;
- Work with DSS to support a campaign to recruit foster families;
- Examine foster care regulations to ensure that there are no burdensome or onerous restrictions that would serve as an unnecessary disincentive to serving as a foster family; Examples of items to examine are requirements for particular types of smoke detectors and window size specifications amongst others, more or less physical in nature;
- Require that all medical (physical and mental) records be provided to prospective foster parents;
- Require greater scrutiny of prospective foster parents of special needs children.

7. Adoptions

Providing a child with a stable, loving home is the ultimate goal of our child welfare system. Adoptions often provide the means to achieve that goal. However, entering into an adoption is an enormous responsibility for the adoptive parents. DSS should take every step possible to ensure that each adoption has a high probability of success, and then work with post adoptive services to maintain that success.

RECOMMENDATIONS:

Agency Action

- Provide potential adoptive parents with the most thorough background information available related to the potential adoptive child. Diseases, disabilities, disorders, and any other physical or mental infirmities should be disclosed to potential adoptive parents;
- Revise the department's definition of "disrupted adoption" to include a more plain and ordinary meaning of what would be considered unsuccessful by community standards;
- Provide quality comprehensive long-term support service to adoptive families and make best efforts to offer assistance beyond the initial post-adoption period.

Legislative Action

- Require that grandparents should be given a preference for adoptions if found to be fit and appropriate in the best interest of the child.

8. Departmental Management – Oversight and Governance

The Subcommittee recognizes that DSS is an agency that is responsible for safeguarding the well-being of the most vulnerable residents of our State; often under very difficult, disturbing circumstances. Managing DSS under the best of circumstances is no doubt challenging. However, regardless of who heads the agency, and regardless of who occupies management positions throughout the agency, the best interests of the children affected by management decisions must drive those decisions. Testimony suggested that the management techniques implemented at the agency during the course of the hearings, and prior to the hearings, focused too much on "numbers" and too little on the best interests of the children. Those techniques appeared to distract DSS'

employees from one of the agency's core missions and proved to have a negative impact on employee morale and focus.

DSS also grants money to multiple third party providers. The testimony indicates that there needs to be better oversight of these grants and how the dollars are being spent.

RECOMMENDATIONS:

Agency Action

- Develop and implement management protocols that focus on positive outcomes for affected children. Program and employee performance and effectiveness should be measured and evaluated based upon a more subjective standard that takes into account more factors related to the outcome of each case rather than simply whether the case is open or closed;
- Develop method to ensure good outcomes and to measure results provided by outside groups and agencies receiving funds from DSS through grants and other means;
- Implement a policy that requires that in order to maintain a caseload, all caseworkers must be certified;
- Provide new and existing employees with up-to-date training. Encourage and incentivize advanced certifications and licenses. For example, an employee may receive competitive step increases in compensation and responsibilities for pursuing and successfully completing a program to be a Licensed Master Social Worker;
- Establish a database to track employee training history and certifications to ensure all training and certifications are up to date and comply with applicable training policies;
- Maintain an ongoing self-evaluation related to employee retention rates. The self-evaluation should include an analysis of why employees are leaving the agency. Through this practice the agency should be able to be more attentive to pervasive employee-related issues and adjust management practices as needed to keep employee retention rates as high as possible;
- Maintain public records of all departmental grant recipients. The records should include the objective and subjective measurement used by the department to judge the grant recipient's effectiveness in delivering the services for which the grant was awarded. DSS should also include in the records an analysis of the grant recipient's effectiveness. The

records should be available on the DSS website so that they can be easily accessible by the public;

- Establish and maintain a statewide integrated child welfare system database so that caseworkers can more easily access data related to their cases from previous departmental involvement;
- Examine instances where individuals have been indicated by a caseworkers to potentially be a sex abuser so that these cases are brought before a family court judge to determine whether they should be placed on the Central Registry of Abuse and Neglect. After an individual is ordered to be placed on this registry, DSS should ensure the expeditious fulfillment of such an order;
- Minimum qualifications for county directors should include specific, relevant experience that would enable them to understand the duties and responsibilities of case workers;
- Management should impress upon all employees that timely and effective communication with members of the public, clients and colleagues is an important priority in ensuring quality outcomes. Responsiveness can help keep workflow progressing, which in turn will benefit children and families;
- Caseworkers should be connected and grouped with colleagues who will be able to assist in caring for and protecting a child both in the public sector and in the private sector. A team model approach to bring multiple disciplines to the table is an essential tool in providing wrap-around services for a child or family in need of care;
- Examine opportunities to better access and utilize Federal funds that may be drawn down to build programs to support children and families;
- Explore the benefits of The Child and Adolescent Needs and Strengths (CANS) assessment tool for designing individualized treatment plans for children and families.
- Statewide leadership should regularly visit staff in the county offices;
- Implement a rapid response team of caseworkers who can be deployed to counties that may have an increase in caseloads exceeding the agency's established acceptable thresholds;
- Replace five year local office reviews with an agency-wide mandate to engage in Continuous Quality Improvement (CQI). Publish CQI reviews of each county office on agency website;

- Engage assistance from the Annie E. Casey Foundation in many areas needing improvement and for ongoing support.

Legislative Action

- Examine whether DSS should be restructured so that it can focus solely on addressing child protective services and other family issues. The current financial aid-related duties executed by the Department would be transferred to the Department of Health and Human Services. A similar structure has been implemented in Arizona. Any consideration of restructuring DSS should pay close attention to the financial implications as any restructuring may have a detrimental impact on DSS. If so, other alternatives should be considered;
- Alternatively, examine whether there should be separate operating divisions within DSS for child protection and for family dependence/independence;
- Work closely with DSS to identify and to provide adequate funding levels both for employees and programs;
- Establish minimum acceptable qualifications for county directors;
- Enact a tuition reimbursement program to assist DSS with its recruiting and retention efforts. The program will provide for tuition reimbursement for qualifying social work-related undergraduate studies at an in-state college or university. The program may also provide for a monetary stipend for living expenses, books, and meals for students majoring in fields related to social work. In return, a student receiving a reimbursement or stipend must commit to work for DSS for four years. If the participant does not complete the four year work commitment, he must repay all tuition and stipends received. Using this model, Kentucky receives 28 cents for every dollar the state spends through the Title IV-E (Foster Care) federal program to defray program expenses;
- Explore the opportunity to take part in the Center for State Child Welfare Data of Chapin Hall at the University of Chicago as a way to share data with other states and receive data that will help in establishing policies to improve child welfare;
- Pursue Title IV-E waiver(s) to provide the state more flexibility in administering child welfare programs;

- Direct DSS to create a dashboard of child welfare performance measures and outcomes to be published online and in an annual report to the General Assembly;
- Create Local Fatality Review Teams to review child fatalities as a result of abuse or neglect; Replace five-year local office reviews with an agency-wide mandate to engage in Continuous Quality Improvement.

9. Cross-Governmental Support

DSS is not the only agency responsible for child welfare in our State. A mix of state and local law enforcement other state and local agencies also have certain responsibilities. To truly provide a comprehensive web of support for the children in our State, each of the involved agencies and law enforcement must work together. The main focus of this report relates directly to scope of authority that the department is assigned but additional matters were brought to the Subcommittee's attention that merit recommendations. Also, members of the General Assembly need a point of contact at DSS to refer constituent issues and contacts.

RECOMMENDATIONS:

Agency Action

- Each law enforcement agency in the State should have an up-to-date policy regarding the prompt reporting of child endangerment to the department. Law enforcement agencies should also provide training to officers related to identifying the signs of child abuse and neglect;
- The Budget and Control Board should continue with plans to modify reporting methods related to state employee turnover rates when an employee leaves one state agency for another. When the Department of Administration takes over these duties from the Budget and Control Board, the DOA should continue work in this area;
- The State Law Enforcement Division should commit more investigators to child death cases;
- Stakeholder agencies should convene a meeting to further integrate their activities and communication with regards to child welfare issues. The stakeholders should form a working group that meets on a regular basis to modify and improve upon their integration and communication strategies. The stakeholder group should include, but not be limited

to, the Department of Health and Human Services, the Department of Mental Health, the Department of Disabilities and Special Needs, the State Law Enforcement Division, the Department of Alcohol and Other Drug Abuse Services, the Vocational Rehabilitation Department, the Department of Education, the Department of Employment and Workforce, the State Guardian ad Litem program, and the Foster Care Review Board;

- Work with the Department of Public Safety and the SC Criminal Justice Academy to provide training to law enforcement officers and agencies both in basic training and for C-1 recertification in areas of identifying and handling cases of potential child abuse and neglect;
- The Cass Elias McCarter Guardian ad Litem Program should continue to recruit, retain and train qualified guardians ad litem to aid in cases of child abuse and neglect. Special emphasis should be placed on maintaining quality training programs to ensure that children and the courts are receiving the highest quality assistance from GALs;
- Identify a single point of contact within the Agency for members of the General Assembly to refer constituent concerns, questions, and contacts.

Legislative Action

- Provide the State Law Enforcement Division with the authority to require an autopsy in child death cases;
- Fund additional investigators at the State Law Enforcement Division committed to child death cases;
- Examine the membership, mission and operations of The SC Joint Council on Children and Adolescents and The Joint Citizens and Legislative Committee on Children to ensure that they serve appropriate roles and combine to meet the needs of policy makers and child-serving agencies in this state;
- Provide support to the Cass Elias McCarter Guardian ad Litem Program to enhance their recruitment and retention strategies for qualified guardians ad litem;
- Continue active oversight of DSS for stimulating and sustaining improvements;
- Remove state-level barriers to sharing data across agencies and focus on risk-based policies. For example, intake and case workers could use better screening tools that

integrate reports of abuse or neglect and information about families pooled from other agencies.

10. Guardians ad Litem (GALs)

Several witnesses from around the state testified that GALs are frustrated with their work with DSS. The complaints include that caseworkers and other DSS staff do not timely return phone calls or emails; DSS ignores the recommendations of the GAL in given cases; and DSS makes decisions for child placement based on criteria other than the best interests of the child after significant GAL involvement. The Sub-Committee recognizes that GALs play an important role in child protective services and their input should be valued, respected, and appreciated.

RECOMMENDATIONS:

Agency Action:

- Implement third party objective review of cases that stay open beyond one year;
- Implement random audits of case files;
- Require Staff to return phone calls and emails timely;
- Implement policy that decision should be made based on the best interests of the child after receiving input from the GAL;
- Require GAL to meet with adoptive parent to assist in screening in adoption cases.

Legislative Action:

- Provide more legal standing for a Guardian ad Litem representing a child in foster care to take DSS before a court of law;
- Require that the Guardian ad Litem be included in discussions regarding adoptions in order to help the process in looking after the best interests of the child.

11. Child Advocacy Centers

There are seventeen (17) child advocacy centers across South Carolina providing treatment, management, and prosecution of child abuse cases. The volunteers, staff, and experts who assist in the cases come from many disciplines, including law enforcement, child protection,

prosecution, mental health, medical, and victim advocacy. They play a significant role in their various communities in meeting certain needs in child protection.

RECOMMENDATIONS:

Agency and/or Legislative Action:

- State law should be amended to allow hearsay testimony from a forensic interviewer at child advocacy centers;
- Enact legislation to allow access to medical records by S.C. Children’s Advocacy Medical Response System child abuse health care providers in cases of suspected abuse and neglect.

12. Preventing Child Abuse and Neglect

In addition to the numerous intervention improvements identified herein, prevention programs are an essential part of the strategy to reduce child abuse and neglect. These actions should prevent a child from ever being introduced into the social services system in the first place resulting in significant savings to the State.

RECOMMENDATIONS:

Agency and/or Legislative Action:

- Support initiatives that work to educate mothers and families on proper nutrition, pre-natal care, and early childhood development as well as appropriate strategies for raising children;
- Expand existing programs that have shown success in improving relationships between parents and children and enhancing the parental skills of families who are at risk for abuse and neglect;
- Explore other evidence-based programs that may be in use in other states that could become models for prevention efforts in South Carolina;
- Explore and implement programs that support and encourage healthy, traditional family unit.

13. Performance Indicators and Long-Term Agency Accountability

Undeniably, DSS has experienced a heightened level of scrutiny over the last year. At least a portion of the conversation has focused on appropriate performance indicators for the Agency

and reliable data to measure such indicators. Both this Subcommittee and the Legislative Audit Council have noted that the Agency has not been routinely reviewing its methodology and conducting annual reviews of key indicators such as caseloads, turnover rates, and employee training.

The Subcommittee and others have spent countless hours reviewing the work of the Agency and believes that ultimately the implementation of the recommendations contained within this report will improve Agency performance. The Subcommittee is fully aware, however, that elected officials come and go and priorities change. The Subcommittee wants to ensure that the Agency and its stakeholders continue to measure and review the performance indicators for years to come. To accomplish this, the Subcommittee recommends creating an independent oversight body to be an accountability partner for the Agency. This concept is not new; other states have done this, and the Subcommittee received testimony from Casey Family Programs that this is a best practice. Although the Subcommittee is not sure at this time of the most appropriate mechanism, it plans to take testimony regarding this subject at a future hearing. At this hearing, the Subcommittee plans to hear from Casey Family Programs, those advocating for an independent Office of the Child Advocate, the Inspector General, other state representatives with a successful oversight function, and others.

In the short term, the Subcommittee has recommended that the Agency create and publish a dashboard of performance indicators. (See Number 14 herein.) Once developed, the Subcommittee believes that having an external entity validate Agency data, at least in the short term, will assist the Agency in alleviating at least some of the scrutiny. The South Carolina Inspector General submitted a letter to the Subcommittee offering to assist the Agency with this validation. The Subcommittee recommends that the Agency engage the Inspector General to determine the most appropriate entity to validate the Agency's measurement of the performance indicators. The Inspector General has offered to provide resources which can be leveraged with DSS personnel resources to conduct ad hoc reviews during this crucial period of change. This would be similar to the Inspector General's work with the Statewide Information Security Review. A small investment in an independent assurance mechanism will provide both the new DSS Director and legislative oversight confidence in the accuracy and reliability of key data used to make critical assessments and decisions.

RECOMMENDATIONS:

- The Inspector General should work with the DSS director to implement the Inspector General's suggestion for ensuring accuracy and reliability of data during the changes which are occurring and will take place in Child Protective Services for the foreseeable future;
- Agency and legislature work together on developing long term plan for appropriate performance indicators and Agency accountability.

14. Measureable Data and Transparency

As indicated in the previous section, the data that DSS provides to its staff, policy makers, and the public must be accurate and reliable. Further, the public should have confidence that the agency is transparent especially when child welfare is at stake.

RECOMMENDATIONS:

Agency and/or Legislative Action:

- DSS should publish an online dashboard of child welfare performance measures and child outcomes;
- Measure services provided by an outside provider by the same standards as if the services were provided by DSS;
- Allow DSS to share data on unfounded cases in specified circumstances.

15. Legislation Passed in 2014

During the 2014 legislative session while the subcommittee was meeting and in response to several issues raised in the Subcommittee's hearings, the General Assembly enacted the following:

- Act No. 281 (R317, H3102) Also known as "Jaidon's Law" was amended following testimony provided to the DSS Oversight Subcommittee to improve child death reports by coroners and require the Department of Social Services to provide detailed caseload and visitation information to the Governor and General Assembly annually. This law also addressed several issue areas that the Subcommittee received testimony on, including the Central Registry of Abuse and Neglect, Foster Care visitation, Termination of Parental Rights (TPR) and reunification.

- Act No. 295 (R329, H4665) Addresses childcare facilities and was amended to increase the authority of the Department of Social Services to conduct inspections, both announced and unannounced, and ensure licensing and registration requirements are being met.

16. Areas to be Covered by Future Oversight Hearings

In addition to following up on issues raised in this report, the Subcommittee plans to hold future hearings in these additional areas:

- Foster Care;
- Termination of Parental Rights;
- Office of Child Advocate that exists in six other states in some capacity;
- Closing regulatory loop holes and licensing of summer camps;
- Examine when DSS begins an investigation and how, in practice, this is carried out;
- Develop plan for oversight beyond composition of current legislative committee and Agency leadership;
- Develop plan for Agency to have permanent data accountability partner;
- Explore improvements that can be made in Family Court by working together to identify those improvements with the Court system including judges and others knowledgeable of the current process.