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Santa Clara County, Department of Family and Children's Services Emergency Placement Assessment, Safety in Out-of-Home Placement, and Resource Family Approval Review

Introduction

As the single state agency responsible for the administration and supervision of the Child Welfare Services (CWS) system, pursuant to Welfare and Institutions Code (WIC) section 10600, the California Department of Social Services (CDSS) is charged with providing oversight to county child welfare agencies that administer direct services to children and families. Pursuant to WIC section 10605(c)(1), CDSS performs various oversight activities to ensure that services protect children, strengthen families, and are focused on safety, permanency, and well-being.

Background

The CDSS has been engaged with Santa Clara County Department of Family and Children's Services (DFCS) for several years, including on-site reviews and communications that began prior to the start of the 2024 Corrective Action Plan (CAP). Following the release of a Findings and Recommendations report that was shared with the county in 2023, CDSS continued to monitor ongoing concerns related to transparency, consistency in policy application, and the overall pace of systemic change. After additional critical incidents occurred in 2023, which highlighted previously known safety concerns and followed the release of the 2023 report, CDSS increased its monitoring efforts and engagement. This ongoing engagement ultimately led to the county being placed under a CAP to address previously identified compliance concerns, including inconsistencies in the application of hotline and investigative policies, challenges in safety planning practices, and questions regarding the role of county counsel in case decisions. Since December 2024, CDSS has formally monitored and supported DFCS through the CAP process.

The CAP included detailed action items to meet the following goals:

- Ensure social workers are included and collaborated with during case promotion, child removal staffing meetings, and during the development of court petitions and ensure there is a mechanism to include meaningful engagement of the social workers' case knowledge when making referral/case decisions;
- Ensure DFCS provides clear and consistent messaging regarding policy revisions to ensure staff have a clear understanding and can implement new policies and practices to ensure adherence and fidelity to regulations;
- Develop and/or strengthen and clarify county policies and set staff expectations related to reporting and investigating new child abuse and/or neglect allegations when a family has an open referral/case;
- Develop and/or strengthen current protocols and ensure staff are aware of required documentation, protocols and timelines associated with reporting critical incidents to CDSS.

- Provide policy clarifications and identify staff expectations related to the development, maintenance, and monitoring of safety plans created with families. Safety plans must include criteria identified within All County Letter 17-107;
- The DFCS leadership to establish methodologies to review their county data to measure the effectiveness of policy and practice changes identified as needing enhancement or improvement through comparative data monitoring for the duration of the corrective action plan for CDSS monitoring purposes;
- Conduct qualitative data monitoring every six months for 18 months, to focus on the areas of concerns presented in CDSS's February 2024 Findings and Recommendations Report; and
- Improve rating accuracy and overall implementation fidelity of the Child and Family Services Review (CFSR) case review process by utilizing and assessing the feedback received during the quality assurance process on the Round 4 On-Site Review Instrument and maximizing training opportunities. Additionally, increase the usage of CFSR case review data in the overall Continuous Quality Improvement process.

Since the CAP was implemented, DFCS has utilized and requested technical assistance from CDSS to develop new policies and procedures and to strengthen pre-existing ones to improve practice. A mid-point review of the CAP was conducted by CDSS on October 7, 2025,10 months after the implementation of the CAP, to inform both DFCS and CDSS on DFCS's progress. This mid-point review highlighted improvements in documentation, more coaching opportunities, and a culture shift that was more focused on child safety. Nonetheless, ongoing challenges remained with communication, consistent messaging and supervision, training, staff inclusion in staffing of referrals, and consistent use of SDM tools and safety planning. The DFCS reviewed the detailed summary from the mid-point review of the CAP and continued to collaborate with CDSS to address the ongoing challenges. The CAP was projected to end on June 30, 2026, with ongoing CDSS oversight to be continued through the county System Improvement Plan over the next five years.

However, In April 2026, CDSS was notified of an open child welfare case in Santa Clara County DFCS, involving the fatality of a two-year-old child. Immediately following this incident, Santa Clara County officials requested that CDSS conduct a review of the county's handling of the case that resulted in the fatality. Because DFCS was already under a CAP, CDSS, with DFCS's concurrence, elected to perform a broader case review that focused on DFCS's emergency placement assessment, Safety Assessment for Youth in Out-of-Home Placement, and Resource Family Approval (RFA) practice and processes.

Executive Summary

The DFCS emergency placement assessment and safety monitoring practices were evaluated through a review of 55 foster care cases and 60 emergency placements utilizing Child Welfare Services/Case Management System (CWS/CMS) and

supplemented by a two-day onsite hard-file review to identify information missing from CWS/CMS. Findings show significant systemic gaps in documentation and timeliness across required emergency placement procedures. Only 6 of 60 emergency placements contained complete and verifiable pre-placement compliance with the statutory requirements for emergency placement as outlined in WIC section 361.4. The majority of placement assessments lacked dated verification of one or more required assessment steps, including missing California Law Enforcement Telecommunications System (CLETS) documentation, incomplete child abuse and neglect records reviews, and unclear criminal exemption determinations. These gaps result in an inability to demonstrate adherence to WIC section 361.4 and related directives. Additional concerns were noted regarding the use of extended visits prior to formalized placements under the emergency assessment criteria, and inconsistent application of documentation processes across cases.

The review of ongoing safety assessments found that although most youth received consistent monthly social worker contact, gaps frequently occurred during social worker transitions or were supplemented informally using supervised parental visitation, as opposed to formal face to face monthly contact. Nineteen cases lacked consistent documentation of safety assessments, often due to vague notes, absence of private discussions with youth, or reliance on contacts in settings other than the foster home for extended periods. Safety concerns were identified in 20 cases, most commonly involving caregiver neglect, unsafe unauthorized individuals in the home, youth behavioral crises, and unsupervised parent contact. Agency responses typically included initiating referrals, reinforcing safety plans, facilitating placement changes, or coordinating medical and mental health interventions.

The RFA review revealed broad non-compliance with required timelines for application submission, home health and safety assessments, background checks, and exemption processes, compounded by inconsistent use of the Binti tracking system, a secure web-based platform that serves as the county's RFA case management system. While the county demonstrated strengths in areas such as language service accessibility, tangible supports for relative caregivers in need, monthly social worker contacts for youth in out-of-county placements, and high-quality supervised visit practices, the overall findings reflect systemic challenges in documentation, verification, and timely completion of key safety-related responsibilities.

Based on review findings, CDSS recommends a series of intensive, time limited interventions to remediate systemic deficiencies identified during the review. It is recommended that DFCS partner with CDSS to comprehensively map and strengthen the emergency placement assessment process, focusing on eliminating barriers to consistent policy application and ensuring comprehensive safety assessments for caregivers. Additionally, DFCS will refine its case transfer policies with a focus on enhancing safety documentation and knowledge transfer and will review alignment between emergency placement assessment and RFA processes to promote consistent

communication, continuity of practice, and holistic evaluation of caregiver and youth safety.

Case Review Methodology

Emergency Placement Assessment and Assessment of Safety in Out-of-Home Placement Review

The sample for the case review regarding emergency placement assessment and Agency Assessment of Safety in Out-of-Home Placements was generated from a random sample of foster care cases. The case list was developed based on the following criteria:

- Cases under the jurisdiction of Santa Clara County DFCS
- Cases that contained a removal where a youth was placed in out-of-home care between March 2025 and March 2026
- Cases that contained an indicator of at least one placement requiring an emergency placement assessment during the period of March 2025 to March 2026
- Cases that included a unique home identifier to ensure each placement home was included only once on the list

A random sample of 55 youth were selected from the generated case list. During the subsequent county onsite review described below, five of the youth's cases were removed from the emergency placement assessment case review because their hard case files were unavailable during the onsite because the hard case files were being actively used by DFCS staff to prepare court reports for upcoming hearings. This resulted in a total of 50 youth's cases subject to the emergency placement assessment review. For these 50 youth, the review included an assessment of all placements during the review period that were subject to an emergency placement assessment. Because several youth had more than one emergency placement during the period reviewed, a total of 60 emergency placements were assessed for compliance with the emergency placement criteria in WIC section 361.4.

For the review that rated child safety, CDSS focused on all 55 youth identified in the sample and they were assessed for safety across the entire identified period of out-of-home care across all placement settings and home approval types.

The period that was reviewed within the case sample was April 2025 through May 2026. The case review contained both structured data collection and qualitative review of narratives to inform the assessment of emergency placements and overarching safety for youth in out-of-home care. The information for these reviews was obtained through CWS/CMS and by accessing Binti. In addition to the electronic record review, a two-day onsite review of the case files was completed with DFCS on June 11 and 12, 2026.

Consolidated information was coded and analyzed by themes to develop the findings and recommendations identified during the review.

RFA Review

The RFA case review utilized the original case review sample with the following criteria applied:

- Cases under the jurisdiction of Santa Clara County DFCS
- Cases that contained a removal where a youth was placed in out-of-home care between March 2025 and March 2026.
- Cases that had an indicator of at least one placement in an RFA home during the period
- The approval date for these homes was not included in the methodology and approval could have occurred at any point in time during or before the youth's placement.
- Cases in which the home was approved by Santa Clara County DFCS, as opposed to a foster family agency or another county.

A random sample of 13 unique RFA homes was selected from the generated case list for review. The case review was conducted based on RFA requirements which were used to assess the county's RFA process. A review of the hard RFA files and caregiver information found in Binti was completed for the 13 approved resource families during the two-day county onsite in June 2026 to assess the county's RFA process. Areas of non-compliance were documented for each family reviewed and the information was consolidated into themes to develop findings and recommendations identified during the review.

Review Findings

The following themes, presented throughout this report, reflect the information gathered from the sources referenced in the methodology section. The findings are organized by practice area and include a summary of the information and description of the themes and patterns identified.

Criteria for Emergency Placement Process

Existing law, pursuant to WIC sections 309, 361.4, and 361.45, dictate that prior to making an emergency placement of a child, the agency shall do all of the following:

1. Conduct an in-home inspection to assess the safety of the home and the ability of the relative or non-relative extended family member (NREFM) to care for the child's needs

2. Cause a state-level criminal records check to be conducted by an appropriate government agency through the CLETS
3. Conduct a check of allegations of prior child abuse or neglect concerning the relative or NREFM and other adults in the home
4. If CLETS information obtained indicates that the person has no criminal record, the child may be placed in the home on an emergency basis

If the CLETS reveals felony and some misdemeanor criminal convictions, the agency may not place the child with the relative on an emergency basis (WIC § 361.4, subds. (b)(2) & (b)(5)). In those circumstances, the relative must go through a live scan background check and the criminal exemption process prior to any placement (*Ibid.*; see also WIC § 16519.5, subd. (e)). The only exception to this prohibition on emergency placement is if the juvenile court authorizes the placement of the child after finding that the placement "does not pose a risk to the health and safety of the child" (WIC § 361.4, subd. (b)(6)).

If the CLETS reveals certain misdemeanor convictions, excluding those for statutory rape, indecent exposure, or financial abuse against an elder, that occurred within the last three years, the agency may consider the relative for emergency placement of the child (WIC § 361.4, subd. (b)(1)(3) [cross-referencing Health & Saf. Code (HSC) § 1522, subd. (g)(2)(B)(i)(II)]). In those cases, the child may be placed only if:

1. The relative has already submitted live scan fingerprints and has a pending criminal record exemption pursuant to HSC section 1522 (WIC § 361.4, subd. (b)(3))
2. The conviction does not involve an offense against a child (WIC § 361.4, subd. (b)(3)(A))
3. The deputy director or director of the county child welfare agency or their designee determines that placement is in the best interests of the child (WIC § 361.4, subd. (b)(3)(B)), and
4. No party to the case objects to the placement (WIC § 361.4, subd. (b)(3)(C))

Summary of Findings Regarding WIC 361.4 Pre-Placement Requirements

- Six of the 60 total emergency placements reviewed had all of the necessary documentation in CWS/CMS and/or the youth's hard case file to ensure that WIC section 361.4 provisions were followed with the appropriate dated documentation, prior to placement of the youth.
- The remaining 54 emergency placements reviewed did not possess dated documentation to support completion of each requirement under the pre-placement provisions of WIC section 361.4. The following issues were identified regarding compliance. Note that multiple issues were present in over half of the placements reviewed:
    - In 3 placements, in-home inspection documentation was missing

    - In 6 placements, an in-home inspection was documented as being completed after the placement date of the youth
    - In 6 placements, the Child Abuse Central Index (CACI) documentation was missing
    - In 18 placements, the CACI review was documented as being completed after the placement date
    - In 15 placements, CLETS documentation was missing
    - In 2 placements, CLETS was documented as being completed after the placement date
    - In 5 placements, CWS/CMS review documentation was missing
    - In 20 placements, a CWS/CMS review for prior substantiated referrals was completed after the placement date
- In the 54 placements with compliance issues the following frequencies represent the number of compliance issues identified as present.
    - One Criteria Missing/Not Timely: 23 Placements
    - Two Criteria Missing/Not Timely: 14 Placements
    - Three Criteria Missing/Not Timely: 11 Placements
    - Four Criteria Missing/Not Timely: 6 Placements
- While not required by law, internal DFCS policy and documentation practices indicate that department approval is required prior to the emergency placement of a youth in a caregiver home. Signed and dated documentation that a department designated authority approved placement with the caregiver prior to or on the placement start date was present in 9 of the 60 placements reviewed.
- There was no greater likelihood of timely and complete documentation whether the reviewed case was the youth's initial placement in out-of-home care or a subsequent foster care placement.
- There was no association between the youth's second emergency placement assessment and a greater likelihood of successful documentation compared to their first emergency placement assessed, in cases where youth had multiple emergency placements reviewed.

Documentation

Regarding DFCS documentation practices, there were several observations across all required pre-placement criteria assessed in the Emergency Placement Review. Documentation of the requirements related to the CLETS checks revealed that in over half of the foster care cases CLETS checks were documented to have occurred after placement, were missing dates of completion all together, or there was no CLETS information in the case at all. Documentation regarding required background checks lacked comprehensive information and details that resulted in the inability to thoroughly assess whether the checks were done according to law and state policy. During the onsite review, in the placement section of the youth's hard case file, DFCS had a copy of an internal Microsoft Excel CLETS summary spreadsheet as opposed to the actual copy of CLETS documentation for the caregivers. This internally created document did not contain the date that the CLETS was requested or the date that the CLETS check

was completed. The onsite team was unable to use this tracker to verify the date that CLETS results were received and when these checks were obtained in relation to the placement date.

Case files did not have consistent documentation of CWS/CMS checks for prior allegations of abuse or neglect. Some cases had full printouts that included a date and time stamp of the query being made. In other cases, only printed screenshots were shown, and these did not have dates or documentation identifying when the allegation check was completed. The onsite review team also observed that dated documentation in the hard file did not match the electronic record dates in the caregiver background check fields in CWS/CMS. Lack of consistency in both timely completion of allegation checks and a uniform documentation practice impairs DFCS' ability to assess prior child abuse and neglect history for potential caregivers prior to the child being placed in their care.

Documentation of the criminal records exemption approval process and its application and usage was unclear. Several cases indicated that the internal DFCS mandatory ERP 49 form (Placement Pending Exemption Memorandums) would be required for caregivers, but corresponding documentation was not located in the youth's case file for the caregiver, despite the youth having been placed in the home. This is not a state required form, and the onsite review team observed multiple cases in which the caregiver's identified charges were dismissed or completely dropped, yet the file also reflected that the exemption process still needed to be completed. It is not clear how DFCS is applying the use of their internal form for the criminal records exemption processes and what criteria is being used to assess the need for this based on the documentation that was available.

Emergency Placement Approval Forms

During the onsite review, a significant number of hard files reviewed were missing signed and dated ERP 819 forms (Emergency Placement Approval), with some missing signatures and dates of approving workers, signatures and dates of approving supervisors, or both. In some cases, there were multiple copies of the ERP 819 form. The Onsite review team did not observe uniform application of this form across the hard files reviewed. While this is not a state required form, the reviews revealed inconsistent use of this DFCS form across case files.

Emergency Placement Approval Home Inspection

A substantial number of cases had the internal DFCS mandatory initial ERP 820 form (Emergency Approval Home Health and Safety Assessment Checklist) that contained minor approval violations (i.e. cleaning solutions/medicines being accessible, unsecured gardening tools/knives). Documentation indicated that the assessed homes did not meet criteria for emergency placement based on the county's emergency home inspection criteria, due to the stated minor violations. However, youth were still placed in

these homes on or before the ERP 820 assessment date. While these cases consisted of minor violations that would not expressly prohibit placement under state statute, the hard case file did not have documentation that these minor violations were corrected prior to or after the placement of youth. There were no subsequent ERP 820 forms or updated contact notes citing any corrections. A substantial number of ERP 820 forms were missing signatures and dates indicating when they were completed or formally approved which resulted in the onsite review team's inability to assess when and whether formal DFCS approval of these homes occurred. This could result in DFCS' own inability to determine verifiable approval dates, thereby impairing its continuous quality improvement process.

According to subdivision (a)(1) of WIC section 361.4, the county child welfare department shall conduct an in-home inspection to assess the safety of the home and the ability of the relative or NREFM to care for the child's needs. It is important to note that an emergency placement home inspection is separate from the requirements of RFA home assessments that occur after an RFA application has been submitted. Home inspections conducted as part of the emergency placement assessments do not need to meet RFA home standards. The DFCS ERP 820 form appears to closely align with RFA home standards and may warrant review for modification of standards to align with emergency placement.

The connection between the home environment assessment, caregiver background checks and an overall evaluation of appropriateness of the placement to meet the youth's needs appeared across these cases as separate assessments and not one cohesive effort to evaluate the placement in relation to safety and the needs of the youth. Documentation for approvals exist as separate activities across case files. Some cases had multiple staff completing individual elements. When case records do not contain consistent information for assessing and evaluating placements this can create gaps in assessments of caregiver safety that must be completed prior to the emergency placement of youth. Ensuring that evaluations and decisions regarding placements are properly assessed, staffed, approved, and documented is critical to youth safety and to the provisions for placement on an emergency basis.

Impacts on Child Safety

The CDSS found inadequate caregiver background and safety checks greatly exceeded instances of inadequate home inspections. When verification of caregiver safety required under WIC section 361.4 is delayed or missing, youth are placed in homes before the county has the required information available to thoroughly assess the safety of an emergency placement. Without these caregiver safety checks, the agency cannot confirm whether caregivers have prior abuse history, criminal record concerns that may prevent the ability to safely place on an emergency basis. Incomplete or inconsistent internal documentation also prevents verification that placements were properly approved, creating undesirable agency liability.

County Strengths

- When documentation was present to make a determination, the onsite team did not identify any caregivers with non-exemptible offenses in which youth were still placed in the home, supporting the county's adherence to this requirement.
- When present, emergency placement home evaluation contact narratives in CWS/CMS provided high-quality documentation of the initial in-home inspection. In these cases, the evaluation included identified actions needed to remediate any deficiencies.
- Emergency assessment documentation and process requirement forms were consistently provided in Spanish in cases with primary Spanish speaking caregivers.
- When tangible items were needed by caregivers to support the emergency placement of the youth (i.e. bedding, bassinets, car seats, cribs) the county actively worked with relative caregivers in supporting the acquisition of these items, including providing financial support when necessary.

Agency Assessment of Safety in Out-of-Home Placement Review

The reviews examined the safety of youth in their placement, for the duration of each youth's time in out-of-home care, between April 2025 through May 2026. The reviews included all placement settings and home approval types in which the youth were placed.

Criteria for Social Worker Contacts and Assessment of Safety for Youth in Out-of-Home Placement

Existing law, pursuant to WIC sections 16516.5 and 16516.6 and CDSS Manual of Policies and Procedures (MPP) section 31-320.61 dictate that youth placed in out-of-home care by county welfare departments shall be visited at least once per calendar month by the county social worker. The WIC section 16516.6(b) mandates that no more than 2 consecutive monthly visits may be held outside of the placement of the youth. The WIC section 16516.6(c) dictates if the visit does not occur in the place of residence, the social worker or probation officer shall document in the case file and in the court report the location of the visit and the reason for the visit occurring outside the place of residence.

Additionally, MPP section 31-320.5, dictates the purpose of the county social worker contact is to assess the safety and well-being of the youth. The WIC section 16516.6 (a) mandates when a county social worker makes a regular monthly contact visit with a youth in their placement setting, the visit shall include a private discussion between the youth and the social worker.

The private discussion shall not be held in the presence or the immediate vicinity of the foster parent or caregiver. The social worker shall advise the youth that they have the

right to request a private discussion to occur outside the foster home. If a youth requests to have the private discussion outside the foster home, that private discussion shall not replace the visit in the foster home.

Summary of Findings Regarding Social Worker Contacts and Assessment of Safety for Youth in Out-of-Home Care

- In 15 of the 55 cases reviewed DFCS did not meet the monthly contact requirements. In these cases, there was at least one monthly visit missing during the period reviewed.
- 38 cases had documentation that monthly contact with a social worker had been completed.
- In 33 of the 55 cases, the county social worker conducted more than 2 consecutive monthly social worker visits with the youth in a setting other than the youth's placement.
- In 19 of the 55 cases, the youth's case did not have consistent documentation of assessments of the youth's safety in placement.
- In 20 of the 55 cases, documented safety concerns were identified during the youth's placement in out-of-home care and information was included about actions taken by the county to address the identified safety concerns.

Themes Identified Regarding Social Worker Contacts and Assessment of Safety for Youth in Out-of-Home Care

<u>Missed or Irregular Monthly Social Worker Contacts</u>

Multiple cases had missed monthly face-to-face county social worker visits with youth, including monthly gaps in contact and cases with extended periods without documented contact. In cases where monthly visitations in the home were missed, there were brief notes describing social worker check-ins with the youth during a portion of the youth's supervised visitation with parents while at DFCS.

Cases in which monthly visits did not occur timely, or were missed for extended periods of time, frequently corresponded to the transition period between different units within the DFCS. Case transfer between emergency response, dependency investigation and ongoing case management sometimes resulted in multiple months without completed face-to-face contact.

<u>More Than 2 Consecutive Monthly Social Worker Contacts Outside of the Youth's Residence</u>

When there were multiple consecutive contacts outside the placement home the most frequent locations for these to occur were school, court, the agency office or during

supervised visitation settings. This pattern contributed to preventing assessment of youth's safety in the placement setting for extended periods. A small number of cases identified multiple months of county social worker contacts utilizing the youth's school as the preferred monthly contact setting instead of the youth's placement.

Cases with large sibling sets placed in different homes were identified as being more likely to experience multiple large group social worker contacts outside of the youth's individual residences.

Documentation of Safety Assessment in the Youth's Placement

In addition to the pattern of monthly visits identified there were also limitations in the quality and scope of the documentation detailing the contacts with the youth. Monthly contact notes frequently contained general information about school and services. Contact notes frequently lacked specific discussions about safety in the placement and overall safety of the youth. In cases where the agency became aware of safety concerns, there was additional and more robust documentation of ongoing safety assessments but only after a triggering event. These events are discussed in the next section of this report.

Additionally, in a small set of cases there was a pattern of not providing or offering a private setting for the conversation with the youth to conduct an individual assessment of safety in the placement.

Identified Safety Concerns in Placement and Agency Actions to Address

When safety issues were present, they were most commonly identified via reported referrals, which were subsequently investigated by the agency as immediate or 10-day response. In a few instances, safety issues were discovered by the primary county social worker during social work visits or from collateral contacts with third parties, resulting in referrals initiated by the primary social worker.

Caregiver neglect or failure to provide appropriate care and/or supervision was the most frequently observed safety issue reported for youth in care. These instances include identification of inappropriate management and oversight of youth's medical conditions, inappropriate or mismanaged infant feeding schedules, and missing youth's medical or other appointments. The most common response to safety concerns that were reported to the department was to initiate an in-person response and open a new investigation. As needed, the department addressed the reported concerns through a change of placement for the youth. In cases where the safety concerns could be addressed in placement, social workers reaffirmed expectations regarding youth's individualized needs and created safety plans to mitigate the specific issue identified.

Safety issues associated with youth behavior both inside and outside of placement was also observed as a safety issue for youth in care. These behaviors include, but are not

limited to, youth's acts of self-harm, missing from placement, substance use, overdose, and physical or verbal altercations. The county responded to these behaviors by offering or providing emergency crisis support, reaffirmation or strengthening of existing safety plans, and modifying existing referrals for support services or initiating new referrals. If necessary, the county moved the youth to other placements, including higher levels of care.

Occasionally, unsafe or unauthorized individuals living with or having contact with the youth in care created a safety concern. In circumstances where the county was aware of this concern, DFCS did investigate and respond appropriately.

The CDSS also identified safety concerns related to unsupervised parent contact. There was limited documentation about the DFCS' response.

Impacts on Child Safety

Missed or inconsistent monthly social worker visits reduce the county's ability to identify emerging or existing safety threats in a youth's placement. When social work contacts repeatedly occur outside of the home, social workers are unable to directly assess the safety of the youth's living environment, resulting in extended periods without verification of a youth's safety in placement. Gaps in contacts when a case was transferred between workers and between units within DFCS, lack of private time with youth, and reliance on informal check-ins limit the county's ability to identify safety concerns or risks. This can lead to reliance on external parties to identify and present safety concerns to the county resulting in new referrals or escalation of identified issues into crisis situations. This pattern delays responsiveness and may result in the department's safety assessments becoming reactive, rather than proactive. When delayed response necessitates a change in placement, the harm to the youth is compounded by the increased instability in placement. Without consistent well documented, monthly youth contacts with the youth in placement, opportunities for early intervention are missed thereby increasing the possibility of undesirable events. Regular visits of high quality result in earlier detection and therefore a prompt departmental response to mitigate or prevent issues from occurring.

County Strengths

- During the CWS/CMS review, the review team observed a notable strength in the county's informal safety assessment and contact documentation that occurred during supervised visitation between the parents and youth.
    - This strength was identified for visits held at the county agency offices and in public/community-based visit settings, both actively during visits and pre/post transportation, when applicable.
    - The depth and detail of supervised visit contact notes provided significant insight into the parent-child relationship and had the capacity to informally

identify supplemental safety and/or case plan concerns that may not be identified during a monthly social worker visit.
    - As long as not being used as a substitute for formal face-to-face monthly assessment, the contact note quality identified has the ability to positively contribute to the primary social worker's assessment of parent-youth relationship, support the overall assessment of parent-child needs, and wholistic case assessment.
- For youth placed out of county, DFCS almost always continued conducting monthly social worker contacts with the youth, not relying on the placement county for courtesy social worker visits. In 15 of the 60 placements reviewed, the youth was placed out of county. In only one case, did DFCS regularly rely on the placement county to conduct courtesy social worker visits.

Resource Family Approval Case Review

The CDSS' review revealed practices that are inconsistent with RFA requirements. The following are the applicable authorities to which CDSS found the county has consistent compliance issues. While CDSS found individual RFA cases that did not conform to other statutory or RFA Written Directives (WD), those appear to be isolated cases. The CDSS therefore does not include those authorities here.

- WIC 361.4(c):
    - Within 10 calendar days following the criminal records check conducted through the CLETS or 5 business days of making the emergency placement, whichever is sooner, the social worker shall ensure that a fingerprint clearance check of the relative or NREFM and any other person whose criminal record was obtained pursuant to this section is initiated through the Department of Justice to ensure the accuracy of the criminal records check conducted through the CLETS and ensure criminal record clearance of the relative or NREFM and all adults in the home pursuant to subparagraph (A) of paragraph (2) of subdivision (d) of Section 16519.5 and any associated written directives or regulations."
- RFA WD, Section 4-08:
    - Following the emergency placement of a child or nonminor dependent with a relative or NREFM, or an extended family member in the case of an Indian child, as described in Welfare and Institutions Code sections 309, 361.45 or 727.05, a county welfare agency or probation department shall do the following:
        - In the case of an ICWA eligible child, consult with the Tribe and determine if the relative, NREFM, or extended family member, will initiate the TAH process, as described in Section 1-04(a), or, within five business days, initiate the Resource Family Approval process as described in paragraph (2) & (3).
        - Ensure the relative, NREFM, or extended family member in the case of an Indian child, completes form RFA-01(A): Resource

Family Application and RFA-01(B): Resource Family Criminal Records Statement.
        - All adults residing or regularly present in the home shall also complete the
- RFA-01(B):
    - Initiate a Home Environment Assessment, including a background check, as specified in Sections 6-02 and 6-03A.
        - Ensure the relative, NREFM, or extended family member in the case of an Indian child, and any other required individuals as described in Section 6-03A shall initiate the criminal background fingerprint clearance within five business days of the emergency placement or within 10 calendar days of when the County or probation department conducted a criminal records check through the CLETS
- RFA WD, Section 5-03B:
    - Prior to conducting any component of a Comprehensive Assessment pursuant to Section 6-01, a County shall require an applicant to complete, sign, and submit form RFA 01A
        - A County may allow an individual to begin pre-approval training, as specified in Section 6-06, prior to the submission of an application.
    - If a child or nonminor dependent is placed in the home of a relative, NREFM, or extended family member in the case of and Indian child, prior to approval on an emergency basis pursuant to Welfare and Institutions Code sections 309, 361.45,or 727.05, a County shall, within 10 calendar days following the criminal records check conducted through the CLETS, or five business days after a child or nonminor dependent is placed with a relative, NREFM, or extended family member, pursuant to Welfare and Institutions Code sections 309, 361.45, or 727.05, whichever is sooner, require the relative, NREFM, or extended family member, applicant to complete, sign, and submit form RFA 01A: Resource Family Application and form RFA 01B: Resource Family Criminal Record Statement.
- RFA WD, Section 6-02:
    - If a child or nonminor dependent is placed in the home of a relative, NREFM, or extended family member in the case of an Indian child, prior to approval on an emergency basis pursuant to Welfare and Institutions Code sections 309, 361.45, or 727.05, a County shall, within 10 calendar days following the criminal records check conducted through the CLETS, or five business days after a child or nonminor dependent is placed with a relative, NREFM, or extended family member in the case of an Indian child, pursuant to Welfare and Institutions Code sections 309, 361.45, or 727.05, whichever is sooner, initiate a Home Environment Assessment, including a background check, as specified in this section and Section 6-03A.

Summary of RFA Review Findings

As described in the earlier methodology section, approval dates for the RFA cases reviewed occurred at any time prior to or during the youth's placement. There have been several versions of RFA Written Directives released with updates to requirements and it is possible that county practice evolved throughout this period. The information below should be considered moving forward with DFCS's RFA program plan.

During the onsite review, 11 of the 13 case files reviewed were determined to be out of compliance with laws and/or regulations regarding RFA. Variations of the following issues were found in the 11 files that were reviewed:

- Youth placed before required criminal record exemption is granted with no record of court order or Deputy Director approval
- Untimely processing of RFA applications
- Untimely health and safety assessments (RFA 03)
- No biennial approval update
- Delays in processing criminal records exemptions
- Untimely livescans
- Documentation missing or incomplete, including but not limited to missing CORI results, missing applications, missing approval forms (RFA 05A), missing signatures on approval

Based on the information above, DFCS appears to be out of compliance on a systemic level regarding timeframes to complete requirements related to the RFA application submission, Home, Health, and Safety Assessments with a completed RFA 03, and criminal background checks for caregivers with a placement prior to approval. Other issues found within case files did not appear to occur consistently enough to demonstrate a practice concern.

Findings Regarding DFCS Use of Binti

Many counties in California have opted to use Binti, a software database system, to help staff track RFA application progress in real time. It allows the RFA worker and their supervisor to easily see at a glance what documents are missing, application timelines and many other valuable tracking tools.

The DFCS, however, does not seem to be using Binti to the extent it was intended. It appears that staff only update information in Binti on a sporadic basis and oftentimes there is missing information which may or may not be found in the hard copy file. Use of Binti in this manner appears to have duplicated tracking activities for staff which is likely seen as burdensome and time consuming.

Recommendations

At this time, continued intervention and monitoring of DFCS by CDSS through the expansion and extension of the existing DFCS CAP is necessary to ensure that state laws and regulations are accurately followed, that DFCS is provided with adequate technical assistance, and that support can be provided through a child welfare oversight perspective. The recommended action steps identified below should be incorporated into the revised CAP which should be implemented no later than November 13, 2026. The review findings indicate a need to focus on both immediate safety and process improvements, as well as areas that may also need to be addressed as part of long-term strategies for system improvement. The CDSS team that worked on this review is also aware of CDSS' recent findings regarding the handling of the case of a child who suffered a fatality in care. Those findings are consistent with the findings of this broader case review and highlight the need for continued partnership between CDSS and DFCS in enhancing caregiver approval and child safety processes.

Recommended Action Steps:

1. Santa Clara DFCS will engage CDSS in a comprehensive mapping of the emergency placement assessment process in order to address and improve the current gaps identified in the review and as part of the corrective action plan expansion. It is recommended that the mapping focus on identifying barriers to uniform application of policy and procedures for assessments. This should include identifying barriers in the assessment policy and process that are intended to increase child safety, including all required criminal and abuse and neglect allegation checks for potential placement caregivers.
2. Develop and/or strengthen and clarify written county policies and set staff expectations on case transfers to ensure stability, consistency, and integrity of child welfare practice for the children and families involved in the cases. If not already identified in county case transfer policy and practice, documenting case expectations regarding the transfer of knowledge associated with the historical assessment of youth safety (i.e. prior substantiated/inconclusive referrals while in out-of-home care, documented safety concerns, documenting known safety concerns which have yet to be formally documented prior to case transfer), ensuring transferred and documented communication of any existing safety concerns, and ensuring the continuity of timely social worker youth visits when cases transition between workers.
3. Santa Clara DFCS will engage CDSS in reviewing DFCS emergency placement assessment process and caregiver completion of RFA approval, post emergency placement. As part of this examination, Santa Clara will review alignment between existing emergency placement assessment and RFA processes, including examining the roles, responsibilities, and relationships between case carrying social workers, placement workers, and RFA workers to support the wholistic assessment of caregiver and child safety throughout these processes.