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# Fresno County Child Welfare Services 2026 On-Site Visit Findings and Recommendations

## 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. The CDSS performs various oversight activities to ensure that services protect children, strengthen families, and are focused on safety, permanency, and well-being. In this instance, following a request from the Fresno County Administrative Officer, the CDSS agreed to conduct a review of communication pathways for reporting child safety concerns, safety and risk assessment policies, the balance between child safety and family reunification, and reunification bypass procedures.

## Background

In March 2026, at a Fresno County Board of Supervisors meeting, concerns regarding child welfare decision making and child safety were brought to the Board by former child welfare services staff. The concerns alleged that Fresno County Child Welfare Services is not adequately addressing abuse and neglect concerns, and that despite staff requests for support in the areas of child safety, concerns have remained unaddressed by the agency. Following these events, the CDSS received a request from Fresno County leadership and the County Administrative Officer, asking the CDSS to conduct a review of Fresno County Child Welfare Services.

A team from the CDSS conducted a two-day on-site visit to Fresno County Child Welfare Services on June 23, 2026-June 24, 2026. The purpose of this visit was for the CDSS team to use a child welfare lens to explore issues related to reunification bypass, reporting of child safety concerns, safety and risk assessments, and family reunification. The CDSS team was comprised of 18 staff, primarily management and leadership level, who oversee front-end policy, system improvement, child welfare workforce, and CWS compliance. The on-site visit consisted of an entrance and exit conference with Fresno County Child Welfare Services leadership and division chiefs, individual social worker interviews, and separate focus groups for social workers and social work supervisors. The Fresno County Child Welfare Services staff who participated in the interviews and focus groups brought expertise spanning the lifecycle of a case: from the initial investigation of a referral to the various phases such as dependency, independent living, and family reunification. The broad range of professional backgrounds ensured that multiple perspectives on the work performed by Fresno County Child Welfare Services were represented to support the overall findings.

Additionally, a case review of 50 referrals and 40 foster care cases was completed. The case review of the referrals was inclusive of both investigated and evaluated out (EO) referrals. Investigated referrals were reviewed for timeliness of response, the length of time required to close each referral, subsequent referrals, and the completion and accuracy of Structured Decision Making (SDM) tools. Foster care cases were reviewed for overall safety assessments, referrals received while the case was open, examining the rationale and process for case decisions, documentation in court reports and case notes, and ongoing case management aspects. The case review process included reviewing documentation captured in the Child Welfare Services/Case Management System (CWS/CMS) to better understand practice across several decision points.

**On-Site Data Analysis and Case Review Methodology**

Prior to the on-site, preliminary findings from a small subset of case reviews were used to inform onsite interview questions and focus group materials. Following the onsite, the CDSS conducted qualitative data analysis on information gathered during the interviews and focus groups while the case reviews continued concurrently. Data coding resulted in the development of categories which were used to identify key findings, patterns, and insights.

Case reviews included both structured data elements and the review of case narratives to identify patterns in practice, decision-making, and system-level findings. A sample of 40 child welfare foster care cases was reviewed. A random sample of cases was selected to ensure sufficient time in care to assess case planning, permanency efforts, safety assessments, reunification practices, and documentation. Inclusion criteria required that the case start date was on or before February 18, 2025, and the case was required to either still be open or have a case end date on or after October 1, 2025, to ensure a minimum of 3 months of overlap with the review period. The removal date was required to be on or before May 18, 2026, and the episode end date was either on or after July 1, 2025, or it remained open.

A random sample of 50 child welfare referrals was also reviewed. The sample was stratified to ensure that 25 investigated referrals and 25 EO referrals would be reviewed. EO referrals were sampled between January 27, 2026, and July 27, 2026, and investigated referrals were sampled between July 1, 2025, and April 1, 2026.

**Review Findings**

The key findings, presented throughout this report, include information gathered from the on-site review as well as quantitative and qualitative data through case review. The key findings are organized to present the data collected, followed by a narrative interpreting the data to identify findings, compliance concerns and practice concerns.

## Hotline Practice and Investigations

Regarding the Fresno County Child Welfare Services child abuse hotline and investigation practices, the following data was gathered from the on-site interviews, on-site focus groups, and case reviews:

*Timeliness*

- The first in-person contact was completed timely in 87.5% of immediate (24-hour) response referrals.
- The first in-person contact was completed timely in 23.5% of 10-day response referrals. Among referrals in which the first contact was initiated after 10-days, it took an average of 17.1 days to make in-person contact. The longest amount of time for in-person contact to occur was two months.
- Immediate referrals had an average investigation closure timeline of 35.3 days.
- 10-day referrals had an average investigation closure timeline of 69.2 days. Per interviews, the untimeliness of closing referrals is related to understaffing, which results in high caseloads.
- Of the 25 EO referrals reviewed, the average number of days between the date of referral receipt and closure of an EO referral was 19 days, with one referral open for 120 days, substantially increasing the average number of days to closure. The median number of days, from referral receipt to closure, was 12 days.

*Re- Referrals and Duplicate Referrals*

- Eleven of the 25 EO referrals were duplicate referrals that contained no new allegations and were associated with another open referral. In some cases, a referral initially designated as a 10-day was subsequently changed to EO after a duplicative referral was received that was designated a 10-day. The date of the subsequent referral was then used as the investigation start date, even though the prior referral date should have been used.
- A pattern of prior and subsequent child welfare involvement was highlighted within the sample of 25 EO referrals:
    - Five referrals involved families with an open child welfare case within one year of the review period.
    - Two referrals involved families with an open child welfare case at the time the referral was received.
    - Twelve referrals had at least one prior referral within the preceding six months that resulted in an in-person response.
    - Ten referrals had at least one subsequent referral within six months that resulted in an in-person response.
    - It is of note that this pattern was also evident in the 40 foster care cases reviewed. In that sample, 10 of the cases reviewed had prior open cases.
- Of the 25 investigated referrals, there were three referrals that were open to a case and 22 referrals closed out. Of the 22 referrals closed out, 14 of those

cases had a subsequent investigated referral within eight months of closure.
- Operational challenges identified within EO referrals included difficulties locating prior linked history and discrepancies between information contained in duplicate referrals.

*Hotline and Investigation Assessments*

- Concerns related to completion of the SDM hotline tool, agreement with recommendations, and overrides of decision/priority were identified in the sample of 25 EO referrals:
    - The SDM hotline tool was not completed in two referrals.
    - The SDM hotline tool response decision/priority was overridden in six of the referrals reviewed. Four referrals were overridden to being EO. Two referrals were overridden to receiving an in-person response.
    - In five referrals, the response priority assigned in CWS/CMS did not match the recommended response priority in the SDM hotline tool. In four referrals, the CWS/CMS response decision was to evaluate out the referral, while the recommended SDM response priority was a 10-day response. In one referral, the CWS/CMS response decision was a 10-day response, while the recommended SDM response was to EO.
- Of the 25 investigated referrals, the SDM Safety Assessment was required for 23 referrals. The SDM Safety Assessment was completed for 14 of those 23 referrals and was completed according to policy for 10 of those 23 referrals.
- Of the 25 investigated referrals, 10 had SDM risk assessments that were completed according to the policy. The other 15 referrals were either missing assessments or contained risk assessments with incomplete information or late completion.
- There was a lack of contact with the family throughout the investigation process which may impact the quality of the assessments.
    - Of the 25 investigated referrals, 12 referrals had only one initial contact, with no subsequent contact with the family or collaterals.
    - Of the referrals that required an in-person response, 12% were closed without any face-to-face contact with the family.
    - Through interviews and focus groups, staff reported that investigation contacts were often inadequate, citing that phone calls were the only contact attempts in some investigations.
- Law Enforcement was identified as a collateral contact in a significant portion of investigations.

**Hotline Practice and Investigations Findings**

Comprehensive reviews were conducted on 25 investigated referrals from Fresno County Child Welfare Services which looked at the timeliness of investigation. Counties are required to initiate in-person investigations immediately or within 10 calendar days, based upon the circumstances of the allegation, in accordance with WIC section 16501(f) and the CDSS's Manual of Policies and Procedures (MPP) Section 31-110.3.

Fresno County Child Welfare Services does a reasonable job of investigating referrals that require an immediate response within the designated timelines, but there are persistent problems in meeting the timeliness of 10-day referrals. This is consistent with data on Federal Measure 2D which counts the number of referrals by time to investigation for completed contacts. Per California Child Welfare Indicators Project data which extracts child welfare data from CWS/CMS, between January and March 2026, 63.5% of 10-day referrals did not receive an in-person investigation within the timeframe specified by the referral response type. This is up 16.6% from the January-March 2025 period and is the highest untimely response rate for 10-day referrals in Fresno County Child Welfare Services since 2004.

In addition to not achieving timeliness upon initiating investigations, Fresno County Child Welfare Services does not consistently meet the timeliness set forth to close referrals per MPP section 31-101.5. That regulation provides that within 30 calendar days of the initial in-person investigation or removal, whichever occurs first, the social worker must determine whether child welfare services are necessary. If services are not necessary, the referral must be closed. Across the 25 referrals reviewed, it took an average of 58.3 days for an investigation to be closed across all referral types. Similar to initiating investigations, 10-day referrals skew the average number of days to close a referral higher. However, it should be noted that independent of the 10-day referrals, the average case closure for immediate referrals also exceeds 30 days.

Through the case file review, it was identified that EO referrals are not processed according to the in-person response requirements and in accordance with the criteria for duplicate referrals. Per MPP section 31-101.5 and further clarified in All County Letter (ACL) No. 17-28, county CWS agencies are instructed to begin the 30-day count from the date of initial removal of the child or the initial in-person investigation, but no later than ten days following the original report of suspected abuse or neglect. Fresno County Child Welfare Services is out of compliance with the regulation in that the start date of initiating an in-person investigation is altered by evaluating out the initial referral that requires an in-person response and using the date of a subsequent referral with the same allegations. This practice results in understating the actual time frame between the initial receipt of a safety concern and the start of the 30-day count.

Additionally, the pattern of prior and subsequent child welfare involvement suggests that many EO referrals occur within the context of ongoing or recurrent child safety concerns rather than isolated events. Prior or subsequent referrals alone do not indicate an EO decision was inappropriate, but the frequency and proximity of these referrals warrant further examination of whether information across referrals is appropriately considered and whether recurring safety concerns are being sufficiently assessed and addressed. There is no structured or consistent method for capturing and documenting the totality of an investigation. The case review team observed that investigation summary notes and investigation conclusions are documented in a single contact note under "conduct client evaluation" rather than in a consolidated narrative or investigation summary document. The absence of a summary document can make it challenging to identify key child welfare practice requirements and decision-making across an investigation.

Reviewing individual contact notes is often necessary to understand the totality of investigative activities. Although not required by state statute, summary narratives or investigation summaries can help streamline the availability of information, which is a critical component for investigations, especially for families who experience re-referrals or multiple investigations. Access to the most comprehensive information supports child welfare agencies in making informed accurate assessments and appropriate decisions during the investigation process.

Challenges with accurately assessing youth may be related to the inconsistent usage of the SDM tools across the intake process at the hotline and the investigation. During the case review, it was identified that Hotline Tools were not consistently or accurately completed. According to MPP section 31-105.2, "The social worker shall complete the Emergency Response Protocol and use a screening tool approved by the CDSS to determine whether an in-person investigation is required" and the SDM Policy and Procedure Manual, further clarifies that the county is required to ensure an SDM Hotline Tool is completed whenever a referral is or will be created. The SDM tools with overrides or a response priority that differed between the SDM and CWS/CMS lacked concrete documentation to explain the discrepancies resulting in missing key information about children and families during the investigation process. When subsequent referrals are received on the family, this lack of information creates a gap that otherwise could have been beneficial information used to inform the current situation. After a referral has been screened in through the hotline, the concern of consistently and accurately completing the SDM tools continues at the investigation level in which the SDM is used to assess the safety and risk of a child. Safety assessments were completed for 61% of investigated referrals where it was required and 60% of referrals had risk assessments that were missing, incomplete, or completed late. This is out of compliance with MPP section 31-125.3, which identifies the necessity of the investigating social worker to timely and accurately conduct a safety assessment utilizing an assessment tool approved by the CDSS. The lack of adhering to Division 31 regulations regarding using assessment tools throughout intake and investigation is a concern that can directly impact the safety of a child.

Another gap identified in the assessment process during investigations was an overall lack of in-person contact with families which is not consistent with regulations. MPP section 31-125.2 states that the social worker investigating the referral shall have in-person contact with all children alleged to be abused, neglected or exploited, and at least one adult who has information regarding the allegations. Additionally, the CDSS released All County Information Notice (ACIN) No. I-52-14 to provide guidance on the best practices in locating families. Within that ACIN, the CDSS recommends that counties attempt at least three in person contacts at different times of day and at different locations (home, school, work, etc.) before a referral is closed. Per interviews and focus groups, there was evidence that Fresno County Child Welfare Services does not adhere to this best practice guidance in that referrals are closed without face-to-face contact and the attempts of face-to-face contact are often replaced with phone calls to initiate contact. In combination with the slow rate of first contact for families with 10-day

referrals, this suggests that Fresno County Child Welfare struggles with making and keeping contact with families throughout the investigation process.

**Ongoing Case Management**

*Documentation*

Regarding documentation challenges in relation to case management, the following data was gathered from the on-site interviews, on-site focus groups, and case reviews:

*Timeliness:*

- Understaffing and high caseloads contribute to increased workload demands, which limit staff's capacity to conduct timely visits and complete required documentation within established timeframes.
- Staff reported completing documentation unpaid after hours to meet documentation requirements.

*Accuracy:*

- Staff reported concerns with the accuracy of documentation citing that supervisory and leadership feedback may result in changes to initial assessments and recommendations.
- Supervisors reported that staff documentation does not adequately capture child safety concerns and additional details are needed.
- The majority of cases reviewed did not contain readily available information related to recommendations or case decisions. Reviewers had to use multiple sources for information gathering including searching in court reports, delivered service logs, and uploaded documents in order to understand and track key decision points.
- The following data was gathered from the case review:
    - Fourteen cases lacked a clear rationale for major case decisions.
    - Seven cases lacked a documented rationale explaining why reunification or bypass of reunification services was recommended.
    - Two cases were identified as voluntary case type in CWS/CMS despite court reports confirming detention.
    - Four cases were missing court reports.

*Child Safety*

Regarding child safety in relation to case management, the following data was gathered from the on-site interviews and on-site focus groups:

- There is not a consistent procedure for staff to follow when a safety concern arises. Staff identified unit meetings and monthly supervision as potential sources for staffing and support.

- More than half of the staff interviewed reported experiencing situations in which child safety concerns conflicted with placement stability or other case priorities.
- Through interviews and focus groups, staff and supervisors identified the following barriers to ensuring child safety:
    - Lack of consistent follow up with families regarding safety concerns.
    - Placement of children in settings that do not adequately meet their individual needs.
    - Investigating referrals by phone rather than through in-person contact.
    - Inconsistent or inaccurate use of safety assessment tools, resulting in children remaining at home without adequate safety assessments. This is consistent with case reviews showing inconsistent or incorrect use of the SDM.
    - Inconsistent agency-wide policies, practices, and expectations, compounded by gaps in training on child safety and family reunification bypass procedures.
    - Inconsistent guidance and expectations amongst supervisors.
    - Safety concerns escalated to leadership are not consistently addressed.
    - Chronic understaffing and high workloads that limit staff capacity to adequately address safety concerns.
- Staff described a heavy reliance on requesting law enforcement assistance in a variety of situations including, first contact for an investigation, removals, sexual abuse allegations, substance abuse in the home, evidence of physical abuse, children missing from care, and welfare checks. Supervisors reported that contacting law enforcement was part of how safety concerns are typically communicated. The case review found that child welfare contact notes frequently reference law enforcement findings in both allegation disposition and overall assessment of child safety. While input from law enforcement is an element of overall assessment, law enforcement findings should not replace agency level assessments of child safety that are conducted according to the law and policy that govern child welfare agency practice.

**Ongoing Case Management Findings**

The CDSS identified several challenges related to decision-making, documentation, and recommendations acknowledged by staff and supervisors in interviews and focus groups. The review of case files reinforced this finding in that there was a lack of clear rationales for key case decisions, inconsistencies across documents, and court reports absent from CWS/CMS.

With the passage of Assembly Bill 636 (Ch. 678, Stats. 2001), California law required the CDSS to establish, by April 1, 2003, the California Child and Family Service Review System to review all county child welfare systems (WIC section 10601.2). The validity of multiple California Child and Family Service Review System outcome measures and other system improvement efforts are reliant on social workers entering documentation correctly and timely in CWS/CMS as mentioned in ACIN No. I-86-06. The lack of proper documentation may result in inaccurate outcome measures which in turn may result in

system improvement plans that do not accurately reflect the strengths and areas for improvement in Fresno County Child Welfare Services.

Accurate and timely documentation is also essential to informing, developing, and updating case plans which are legally required and crucial for ensuring child safety, well-being, and permanency. WIC section 16501.1 and MPP sections 31-206 through 31-235 require social workers to document and update the case plan goals and any changes in the case plan (e.g., treatment services, providers, or placement changes) at least every six months. Without documentation of services and the results of Integrated Practice-Child and Adolescent Needs and Strengths and Child and Family Team Meetings, there is no evidentiary support for the case plan updates.

When decision-making is not clearly articulated through documentation, supervisors cannot effectively review it, courts cannot adequately evaluate it, and subsequent social workers inheriting a case lack the contextual information needed to provide continuity of care. Additionally, inconsistent and missing documentation can lead to safety concerns not being flagged or tracked appropriately, which is a concern compounded by the finding that there is not a consistent procedure for staff to follow when a safety concern arises.

Staff and supervisors identified several barriers that impact the staff's ability to assess and ensure child safety throughout the case, which are focused on a lack of consistent policies, procedures, guidance, or training across the agency. Due to a lack of proper guidance and training, safety assessment tools, like the SDM, are not implemented consistently or correctly across the Fresno County Child Welfare Services. ACL No. 09-31 states the use of the standardized SDM safety and risk assessments tools ensure families are systematically assessed for safety, risks, and needs throughout the life of the case. In addition, use of the tools promotes a uniform and consistent practice of assessment for each social worker, as well as provides consistency in service delivery and child protection throughout the state. It is important that not only social workers understand the proper use of the tool, but that supervisors and managers are familiar with the assessment tool, monitor its consistent use throughout the life of a case, and provide guidance and support to social workers regarding its implementation as well as the interpretation of the indicators. The CDSS and the counties share the common mission of ensuring children remain safe in their homes and when this is not possible, placing children in a safe environment free of abuse and/or neglect. Proper use of the SDM safety assessment tools throughout the life of a child welfare case assists the social worker and their supervisor in monitoring safety and risk factors for children and families.

**Achieving Permanency**

Regarding the Fresno County Child Welfare Services permanency practices, the following data was gathered from the on-site interviews, on-site focus groups and case reviews:

- The following data was identified through the in-person interviews and focus groups regarding WIC section 361.5, providing family reunification services:
    - Staff described having limited influence over their cases decisions when their recommendation conflicts with those of supervisors or upper management. Case worker recommendations regarding the provision of reunification services were described as frequently overridden or modified.
    - Staff explained that some supervisors have dismissed court reports written by staff and written up their own, omitting key information.
    - Staff described tension between assessing for bypass and offering reunification services that shape how reunification recommendations are developed. Staff noted there have been inconsistencies over time with the agency's approach to reunification services in cases where bypass applies. Currently, the perception is that division leadership favors reunification and will override the recommendation to bypass without having knowledge of the families involved.
    - It was reported that some staff went on leave due to a lack of training on bypass procedures and the bypass experience being intimidating and a power struggle with leadership.
- Family Reunification Panels are assembled to determine whether to bypass family reunification services and typically include agency staff and the family.
    - Per focus groups, supervisors indicated that family reunification panel recommendations are ignored, and that Fresno County Child Welfare Services leadership culture is what determines how bypass recommendations are handled. The Division Chief, who is not present at the panel, makes the final decision.
    - Staff expressed concern about the emphasis on offering services, noting that parents who are offered and complete services are likely to reunify with their youth regardless of appropriateness based on case circumstances and child safety.
- The case file review for bypass decision making found that 35% of the cases reviewed included documented circumstances for consideration bypassing family reunification services.
- The case file review found that reunification decisions are often based on the parent completing required services and does not consider other assessments or circumstances of the case.
- The case file review identified 12 cases where a child returned home via reunification or trial home visit (THV). Of those cases,
    - 41.6% of children were involved in referrals within six months of returning home.
    - 83.3% were returned home without any SDM safety or risk re-assessment.
    - 2 cases reviewed had remaining safety concerns documented at the time that reunification was recommended or approved.

*Achieving Permanency Findings*

Per WIC section 361.5, family reunification services are required when a child is removed from a parent's or guardian's custody. WIC section 361.5(b) states that reunification services need not be provided to a parent or guardian when the court finds, by clear and convincing evidence, case circumstances consistent with one of seventeen identified criteria. Leadership, supervisors, and staff, all acknowledged challenges with decision making and agency practice for offering reunification services in cases where service bypass may be applicable. All levels of staff reflect child safety as the primary focus of case decisions, however, leadership level staff see services and safety as individual assessments for case decisions, while staff remained focused on the decision to offer services as the central safety theme. There is a disconnect between the use of family reunification panels for assessment of service provision, final case recommendations, and the shared goal of child safety. Neither leadership nor staff were able to explain the discrete assessment criteria that are applied when making reunification service recommendations. Under the statute, services need not be provided in certain circumstances. In developing reunification recommendations, the social worker is required to investigate the circumstances leading to the removal of the child and advise the court whether there are circumstances that indicate that reunification is likely to be successful or unsuccessful and whether failure to order reunification is likely to be detrimental to the child. The emphasis on determining if a family meets criteria for WIC section 361.5(b) coupled with a lack of clear criteria for assessing the circumstances of each individual removal in reunification recommendations creates the potential for gaps in both child safety and family preservation.

**Indian Child Welfare Act**

Regarding the Fresno County Child Welfare Services Indian Child Welfare Act (ICWA) practices, the following data was gathered from the on-site interviews, on-site focus groups and case reviews:

- ICWA inquiry was not completed in 32% of referrals reviewed, with 8% of referrals not including ICWA inquiry because of an inability to make face-to-face contact with families.
- Referrals did not have structured investigation narratives that summarize the activities of the investigation and recommendations, as a result it was challenging to identify if ICWA activities such as inquiry/notice, tribal engagement, and tribal collaboration were conducted during the investigation.
- Through county staff and supervisor interviews and focus groups, there were inconsistencies in identifying ICWA-related challenges. While 26.7% of staff interviewed stated that they do not encounter any challenges, other staff identified various challenges, including a perception that ICWA requirements take a long time, a lack of clarity, and court issues.

*Indian Child Welfare Act Findings*

The Fresno County Child Welfare Services ICWA practices identified through the data reflect broader agency-wide concerns outlined in this report regarding documentation practices. As previously discussed regarding documentation, investigation narratives provide critical and necessary context and history about children and families that are used to inform case planning and decision making. For Indian children, this context is also important for understanding the child's tribal and family connections and ensuring that those circumstances are sufficiently considered during case planning and decision-making.

Fresno County Child Welfare Services is out of compliance with WIC section 224.2 regarding completing an ICWA inquiry for every referral, in that an inquiry was not completed in 32% of referrals reviewed. Per WIC section 224.2, the duty to inquire about Indian ancestry or heritage begins when the county is first contacted regarding a child, including asking the reporting party if they know whether the child is or may be an Indian child. At the first contact with the child and each family member, including extended family members, the department has a duty to inquire that child is or may be an Indian child. Furthermore, MPP sections 31-101.11 and 31-110.31 require that for all referrals, a county shall inquire with the reporting party, the child, if the child is old enough, and the child's parent(s), legal guardian(s), or the child's Indian custodian, whether the child is or may be an Indian child and shall identify and document each response in the case record. If during inquiry, any information is presented that gives the social worker or probation officer "reason to believe" the child is an Indian child, the agency must engage in further inquiry (WIC section 224.2(e)). Further inquiry must include, at a minimum, engaging with the family by interviewing the parents, guardians, Indian custodian(s), and extended family members about the relevant family background required by WIC section 224.3(a)(5) and WIC section 224.2(e)(2)(B). This background information is needed to effectively fulfill the agency's duty to notice the child's Tribe if it is known or there is reason to know the child is an Indian child. Proper inquiry and notice are important to ensure that an Indian child/family's Tribe(s) are notified and have the ability to intervene, which is their legal right under the ICWA. It is concerning that 8% of the referrals that didn't include an ICWA inquiry had documented that it was because of an inability to make face-to-face contact with families, when face-to-face contact to inquire is not a requirement and the inquiry process is expected to begin at intake with the hotline call.

Lastly, varying staff experiences with ICWA-related challenges further supports that a lack of consistency in skill, knowledge, and application is a significant area for improvement for Fresno County Child Welfare Services, as reflected across interviews, focus groups, and case reviews. We highly recommend that ACL 23-46 be reviewed and discussed with staff, and used as a reference, as it covers ICWA inquiry, reason to believe, reason to know, and noticing requirements.

**Child Welfare Decision Making and Support**

Regarding the Fresno County Child Welfare Services agency structure, decision making and communication practices, the following data was gathered from the on-site interviews and on-site focus groups:

- Staff reported the following challenges in using the chain of command to raise concerns about investigations or case direction.
    - Concerns that their assessments are often ignored.
        - Concerns regarding experience with retaliatory decisions (e.g. being moved into a non-preferred unit).
    - Staff viewed escalation as ineffective due to limited supervisory support, leadership remaining uninvolved, or concerns about retaliation.
- There are inconsistent expectations and guidance amongst leadership, which results in supervisors receiving and interpreting direction from division chiefs differently.
- Staff and supervisors reported a power struggle in which there are staff who do not respond to supervisory feedback and supervisors who override staff recommendations and make significant case decisions (e.g., family preservation versus removal, case closure) without consulting the assigned case worker.
- Supervisors identified a lack of power and authority, reporting that leadership make and enforce decisions that do not address child safety and well-being.
- Staff are seeking consistent guidance and expectations from supervisors and leadership. Some staff indicated that if one supervisor doesn't give them an answer or approval they agree with, they will ask another supervisor in order to get the response they are seeking.
- Staff identify inconsistent leadership, a lack of face-to-face contact with leadership, and an overemphasis on metrics and outcomes data to drive case decisions as challenges related to leadership.
- There are inconsistencies among Emergency Response supervisors regarding policies, procedures, and staff expectations. Differences include acceptable caseload sizes, how long referrals remain open, what constitutes a face-to-face contact attempt, and the adequacy of closing assessments. Supervisors also vary significantly in their review of staff work, with some staff having minimal or no work reviewed.
- Access to supervision is inconsistent, with some staff lacking a consistently assigned supervisor and others experiencing limited supervisor availability for consultation, guidance, and support.
- Staff and supervisors raised concerns about the recent leadership restructuring, including the lack of program managers overseeing key program areas and concerns that the ombudsperson is making case level decisions.
- Leadership acknowledge that the reorganization of the agency structure has changed county processes and created ongoing challenges in workflows.
- The division lacks regular in-person meetings to provide clear and consistent communication across the division.

*Child Welfare Decision Making and Support Findings*

Fresno County Child Welfare Services staff and supervisors identified inconsistent expectations amongst supervisors and leadership as a primary factor affecting agency-wide practice and case-specific decision-making. Division chiefs and supervisors were described as applying policies and procedures inconsistently, resulting in decisions that may vary based on the who in the chain of command made the final decision rather than case circumstances and assessments. Leadership acknowledged that the agency's organizational restructuring has affected workflow and created unintended operational challenges. This agencywide inconsistency in guidance and expectations creates an environment where staff at each level feel their professional judgment isn't trusted or respected and can be overridden based on metrics, outcomes data, or personal bias.

**Staff Feedback and Recommendations**

Staff and supervisors within the interviews and focus groups identified opportunities to address current challenges and strengthen practice.

A primary concern was understaffing, resulting in high workloads and staff burnout. The most frequently identified priorities were workload reduction and increased support, including administrative assistance. Staff emphasized the need for open communication and proactive supervisory support, particularly for after-hours shifts, as well as restoration of previously available resources such as data-entry support, cultural brokers, and substance abuse specialists. Case mapping with supervisors was also identified as a valuable practice that is no longer consistently utilized.

Staff and supervisors also identified a significant need for increased consistency and training across all levels of the agency. Experienced staff and supervisors advocate for more training due to concerns that service recommendations are becoming less individualized to family needs and more generic across all families (e.g. parenting classes, drug treatment programs). This is of particular concern due to the reliance on service completion as a primary indicator for reunification without sufficient consideration of other case-specific safety threat factors. Suggested training includes SDM and Safety Organized Practice, with consistent training across positions. Concerns were also raised that the former training process of shadowing staff and hands on support were superior to the current training process which does not adequately meet staff needs or prepare new workers for practice.

Taken together, the feedback suggests that Fresno County Child Welfare Services' efforts to improve child safety and decision-making should consider the relationship between manageable workloads, a strong training program, supportive supervision, and building upon previous successful practices. Strengthening these areas may help promote greater consistency in practice while supporting staff in making decisions that remain focused on child safety and the best interests of the child.

*Recommendations*

At this time, intervention and monitoring of Fresno County Child Welfare Services by the CDSS is necessary to ensure that State laws are accurately followed by all Fresno County Child Welfare Services staff. This report has outlined key findings that have immediate impacts on child safety, as well as areas that may also be addressed as part of a longer-term strategy for system improvement.

The CDSS has identified intake and investigation processes discussed in this report as areas requiring immediate correction. The CDSS will support Fresno County Child Welfare Services in the development of a 12-month plan in which Fresno County Child Welfare Services must address the immediate action steps, correct or update existing county guidance to the current state guidance and disseminate it to staff. The following activities and action steps will take place over the 12-month period following the receipt of the report.

Within three months of receiving this Findings and Recommendations report, Fresno County Child Welfare Services will:

- Meet with the CDSS to review policy to ensure it is in accordance with state guidance.
- Identify action steps and implementation plans for identified changes.

During months three to nine of the plan, Fresno County Child Welfare Services will:

- Implement the identified action steps and strategies to address the immediate action recommendations.
- Engage the CDSS during implementation if additional barriers or challenges are identified.

The CDSS will perform a new case review at the end of a 12-month period, using months nine to twelve as the review period. The CDSS will:

- Produce a summary of the data findings to show whether practice has been corrected and complies with state law, and monitor compliance changes across all immediate action recommendations.

If the case review does not demonstrate that county's practices are in compliance at that time, the CDSS will move forward pursuant to its oversight authority under WIC section10605 to require a Corrective Action Plan.

*Recommendations Requiring Immediate Action*

1. Fresno County Child Welfare Services will immediately comply with MPP section 31-105.2: "The social worker shall complete the Emergency Response Protocol and use a screening tool approved by the CDSS to determine whether an in-person investigation is required." To improve response priority decision making, SDM Hotline Tool improvement should focus on timely completion, and consistent use of definitions and thresholds.

2. Fresno County Child Welfare Services will immediately require their investigating workers to complete an SDM safety assessment for every investigation, prior to leaving a child in or returning a child to their home or placement, per MPP section 31-125.3. Additionally, investigating workers will be required to complete an SDM risk assessment for every investigation, prior to investigation closure, per MPP section 31-125.4. These tools should be completed solely by the investigating worker and later approved by the worker's supervisor/manager.
3. Fresno County Child Welfare Services will cease the practice of altering the start date of initiating an in-person investigation by evaluating out an initial referral that requires an in-person response and using the date of a subsequent referral with the same allegations. Fresno county will immediately comply with MPP section 31-101.5 requiring that county CWS agencies are to begin the 30-day investigation count from the date of initial removal of the child or the initial in-person investigation, but no later than ten days following the original report of suspected abuse or neglect.
4. Fresno County Child Welfare Services will immediately comply with MPP section 31-110.2 and MPP section 31-125.2, requiring that social workers conduct in-person child abuse and/or neglect investigations and "have in-person contact with all of the children alleged to be abused, neglected, or exploited, and at least one adult who has information regarding the allegations," unless otherwise specified in regulations. Additionally, Fresno County Child Welfare Services will adhere to ACIN No. I-52-14 for guidance on best practices in locating families prior to closing referrals.
5. Fresno County Child Welfare Services will engage with the CDSS to develop and/or strengthen and clarify written county policies and set staff expectations related to required elements of investigation including methods of documentation, to comply with investigation standards and improve continuity between investigations when there are subsequent referrals.

**Longer Term Action Steps**

The CDSS and Fresno County Child Welfare Services will also work together to develop longer-term action steps to ensure processes and procedures are created and implemented to elicit lasting systemic changes. These longer-term action steps will address findings discussed throughout this report and may be integrated into ongoing technical assistance with the CDSS or into the Board of Supervisors approved five-year System Improvement Plan (SIP):

1. Fresno County Child Welfare Services should establish a clear, written communication plan regarding policy and procedure revisions while embedding a consistent feedback loop to ensure staff remain informed and engaged in policy and practice changes, as well as understanding the meaning behind the changes in county practices to ensure adherence and fidelity to regulations.
2. Fresno County Child Welfare Services should review current supervisor's expectations and practices and update or revise expectations for supervision.

This may include reviewing current and available training and professional development opportunities to improve skills to ensure consistency across teams.

3. Fresno County Child Welfare Services should review existing policy and practice guidance regarding family reunification service recommendations to ensure that case recommendations align with requirements for safety assessments for each individual set of case circumstances.
4. Fresno County Child Welfare Services should develop and/or strengthen and clarify written county policies and set staff expectations related to what documentation must be recorded in the Statewide Child Welfare System of Record and around documentation timeliness for all case-related documentation.
5. Fresno County Child Welfare Services should engage with Evident Change to request technical assistance to train staff on the appropriate, fidelity use of hotline, safety, and risk assessment tools.
6. Fresno County Child Welfare Services should provide comprehensive training on ICWA requirements and regulations for all staff and supervisors, and integrate ICWA inquiry and notice requirements into child welfare processes and procedures, beginning at referral.
7. Fresno County Child Welfare Services should review their current training process and collaborate with the Regional Training Academy for agency-wide trainings in topics such as Safety Organized Practice, SDM and coaching opportunities.